UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
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PETER ALLEN, et al.,

Plaintiffs,

v. 19 Civ. 8173 (LAP)

NEW YORK STATE DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION, et al.,

Defendants.

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New York, N.Y.
February 6, 2023
10:41 a.m.

Before:

HON. LORETTA A. PRESKA,

District Judge

APPEARANCES

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THE COURT: Good morning, Ms. Agnew.

MS. AGNEW: Good morning, your Honor.

THE COURT: Good morning, Mr. Morrison.

MR. MORRISON: Good morning, your Honor.

THE COURT: How are you feeling?

MR. MORRISON: Much better.

THE COURT: Good. Glad to hear it.

Ms. Kiley.

MS. KILEY: Good morning, your Honor.

THE COURT: Good morning. And who else is with you?

MS. KILEY: I have Will Nolan, Jennifer Thomas, and Gabriella Levine.

THE COURT: Okay. Are we able to begin with a witness or do we have to talk about documents first?

MS. AGNEW: I think we have one pending motion, your Honor, and then we would like to make an oral motion. We did not ever receive any form of expert disclosure for defendant Moores, so we want to make sure that no expert testimony will be tendered this morning. I did remind Mr. Nolan during a December 5th, 2022 meet and confer that we would move to preclude any expert testimony if we didn't get the disclosure — we have not. Then we also have the pending motion about the related disclosures from Friday.

THE COURT: And we're okay on the expert, Ms. Kiley?

MS. KILEY: There will be no expert testimony.

THE COURT: Do we have to do the document discussion now before we take testimony or can we start the testimony?

MS. KILEY: No, your Honor, we can start with testimony.

THE COURT: Shall we go ahead with that, then?

MS. AGNEW: Sure. That's fine with me, your Honor.

THE COURT: Very good. Let's go.

MS. KILEY: Your Honor, we would like to call Dr. Moores.

CAROL MOORES,

called as a witness by the Defendants,

having been duly sworn, testified as follows:

THE DEPUTY CLERK: State your name and spell it for the court reporter.

THE WITNESS: Carol Moores, C-a-r-o-l M-o-o-r-e-s.

THE COURT: Ms. Kiley.

DIRECT EXAMINATION

BY MS. KILEY:

Q. Good morning, Dr. Moores.

A. Good morning.

Q. Dr. Moores, can you please share with the Court your educational background.

A. I went to medical school and have an MD. I have a master's in public health and a master's of science in health administration. I completed residencies in family medicine and

public health.

Q. Where did you attend medical school?

A. The Uniformed Services University of the Health Sciences.

Q. Were you in the army?

A. Yes, I was.

Q. And can you please share with the Court for how long you were in the army?

A. I was active duty for 24 years.

Q. And thank you for your service.

A. Thank you.

Q. Can you tell the Court a little bit more in detail about your role as a doctor in the U.S. Army?

A. I was primarily primary care doing family medicine for most of that time. That included providing direct care to patients, both inpatient and outpatient, all ages, active duties or family, retirees and their families. I also was a flight surgeon. So I transported patients on med evacs and took care of aviation units. I also was faculty for numerous residency programs. I was full-time for family medicine residency and part-time at other places for family medicine residencies, and a public health residency.

Q. When did you complete your service with the United States Army?

A. I was retired in 2010.

Q. And what did you do after 2010?

A. Initially, I had to be without work because I was retired due to a medical disability, which was still symptomatic and I wasn't well enough to work for a few years. I then went onto -- when I started having improvement with my treatments, I started doing some volunteer work, which was administrative in nature, until I started working with Department of Corrections.

Q. When did you begin working with the Department of Corrections?

A. In 2016.

Q. What were you hired to do with the Department of Corrections?

A. Initially, I was a regional health services administrator.

Q. What does that mean?

A. I did administrative work for the agency, mostly dealing with -- my position was dealing with providing and obtaining the documents for FOIL requests, for discovery requests, and to assist with creating documents for the policy committee. I would visit facilities with certain outside organizations in order to report back to the chief medical officer about any issues that he wanted to hear about. I also helped them with some efficiency projects with the New York State Lien Program.

Q. For how long were you a health services administrator?

A. About three years.

Q. What did you do after that?

A. Then my disability improved enough so that I could do

physical exam again. So I got a New York State medical license and approached the chief medical officer to offer my services in the clinical arena.

Q. What was your position once you were able to do that?

A. Clinical physician 2.

Q. Where were you assigned?

A. I was assigned to central office to work for the chief medical officer for whatever he had -- whatever projects he wanted me to work on.

Q. And where did you do the clinical work?

A. Initially, I spent time shadowing some of our strong physicians. I did some shadowing at Washington and Great Meadow correctional facilities and Coxsackie, where the main area is.

Q. How often were you seeing patients initially?

A. Initially, I did -- I was just shadowing with them until I started working regularly at Elmira Correctional Facility in 2019.

Q. And for how long were you doing clinical work at Elmira?

A. Nine months.

Q. When did you become the deputy chief medical officer?

A. It was, I believe, September 2020.

Q. When you became deputy chief medical officer, were you still doing the clinical work?

A. Intermittently, yes.

Q. Can you please describe for the Court a little bit more about what your duties were as the deputy chief medical officer.

A. They were to do any project that the chief medical officer asked me to do. Most commonly, it was where he knew that maybe there was an issue at a specific facility and asked me to go and try and figure out the origins of the issue and how we might solve it.

Q. For how long were you deputy chief medical officer?

A. Until Dr. Morley resigned his position in March 2022.

Q. And what is your title now?

A. Chief medical officer and deputy commissioner.

Q. What are your duties now as the chief medical officer?

A. To oversee the health services for the department.

Q. Dr. Moores, what other licenses or certifications do you currently have?

A. I'm certified with the American Correctional Association as a professional and with the National Commission for Correctional Healthcare as a health services administrator.

Q. Can you explain a little bit more about what those two certificates mean?

A. I had to do -- I had to pass exams for each and complete the required education for each, which has to do with correctional healthcare.

Q. And could you speak generally, how is correctional

healthcare different from healthcare in the community?
A. We have to be concerned about the security issues and the fact that we have -- our patients are moving on a very regular basis from one facility to another or in and out of the agency. With those circumstances -- some of them, when they come in, they've not had the opportunity to have adequate healthcare for some period of time. Although, some of those can be -- some of the community can also have that same situation. Those are the things we have to pay particular attention to.
Q. Dr. Moores, how many facilities are in New York State?
A. 44 in the state system.
Q. Approximately how many individuals are in DOCCS' custody?
A. A little over 31,000.
Q. How many medical providers are employed by DOCCS?
A. We've got a little over 120.
Q. What is the breakdown of that 120?
A. At least a little more than half are physicians and the rest are nurse practitioners and physician assistants.
Q. What is the role of the facility health services directors?
A. They have a responsibility of overseeing the healthcare within their facility. They are responsible for overseeing the supervision of the other providers, also.
Q. Is there a facility health services director at each facility?
A. Not currently.

Q. What about the role of the regional medical directors?
A. The regional medical directors have some specific tasks that are assigned to them, primarily to review the referrals back at preliminary denials by Kepro, which is the vendor agency that reviews for criteria to see if they'll be approved. They also go to mortality reviews and they go to the quarterly QI meetings. They're available to answer questions to facility staff.

THE COURT: Doctor, would you spell the agency for the court reporter. Referrals that are denied by --

MS. AGNEW: He has a key, your Honor, that has it for him.

THE COURT: Thank you. I take it back.

Q. Are the facilities' health services directors and the RMDs part of that 120 providers that you just testified to?
A. Yes.
Q. Are there any other titles within health services that we haven't already talked about?
A. There are the nursing staff. There's a nurse administrator that's supposed to be assigned to each facility, sometimes more than one if it's a -- if it has a bigger health services contingency. And there are the staff nurses. There are dental staff. Sometimes there are x-ray techs. There are pharmacists and pharmacy techs. There are office assistants that help with medical records keeping. At the executive level at the

facilities, there are -- some of the facilities have a deputy superintendent for health.

Q. Who do the providers report to?

A. The providers within a facility, it depends on who they have there, but ultimately it is to the superintendent. So, a direct supervisor will be chosen depending on the personnel they have at that facility. So it will -- the nurses usually will report to the nurse administrator. The nurse administrator sometimes reports to the FHSD and sometimes to one of the executive team. The FHSD usually reports to one of the executive team. The executive team will be one of the deputy superintendents or a first deputy superintendent.

Q. Dr. Moores, when you received your medical license, did you take an oath?

A. Yes.

Q. And what is that oath?

A. The Hippocratic Oath.

Q. What does that mean?

A. First, and as everyone always recalls, is first do no harm. You do everything you can to try to take care of your patients, but always keep in mind that you're of service to them and you need to look at the big picture.

Q. What are your ethical duties as a healthcare provider?

A. To make sure that my patient is taken care of to the best of my ability.

Q. To uphold some of your ethical responsibilities, do you have to stay up to date on medical literature?
A. Yes.
Q. Are you required to do so?
A. Yes.
Q. How do you access medical literature?
A. I have various internet sites that I go to and I use very specific references, like uptodate.com.
Q. And do you read literature specific to pain management?
A. I do.
Q. What is chronic pain?
A. Chronic pain is the condition where the patient has a discomfort that is there at such a frequency and time period. That's really -- anything that falls in that category is chronic pain.
Q. What causes chronic pain?
A. There are all kinds of ideologies for chronic pain. For some patients, it can be identified and some patients it is very difficult, and that's an area of ongoing research within the pain management specialty area to get a better idea of why there are some scenarios where we can't figure out exactly what is causing it and how we might be able to intervene.
Q. And generally, how is chronic pain treated?
A. Chronic pain requires an assessment by the provider with -- the first goal is to see if they can figure out the diagnoses

that are contributing to that chronic pain. If you know the diagnoses, you're more likely to come up with a treatment that is going to be effective, and also because, depending on the diagnoses, some conditions can be treated with intervention such as procedures, surgical procedures and such rather than just medication or a change in their activity levels and lifestyle changes.

Q. Can chronic pain be cured?

A. Unfortunately, with a very significant portion of people with chronic pain, even the experts can't come up with ways to cure it entirely. The goal for somebody where they do not have a curable type of chronic pain, the goal is to figure out using the tools that are available to improve it so that it's more tolerable and that the person is more functional in their chosen life.

Q. Do you have experience with chronic pain patients?

A. Yes, I do.

Q. Can you briefly describe your experience.

A. I took care of thousands of chronic pain patients within the army and had chronic pain patients when I took care of patients within the DOCCS facilities.

Q. Approximately how many prescription pain medications exist to treat chronic pain?

A. I don't -- I don't even know. There's a lot.

Q. Could you please explain the different categories of

chronic pain medication, beginning with the strongest level.
A. There are go-to categories of pain medications, which are generally thought about when you have somebody with either acute or chronic pain. The strongest pain medications are the opioids. There is quite a few in that category, such as Oxycodone, methadone, fentanyl. Then there are other categories of medications that aren't necessarily considered specifically pain medications, but can sometimes be helpful with chronic pain scenarios or with certain types of pain etiologies such as the muscle relaxants and some antidepressants and some seizure medications. For those medications, it's not really clear how they might work for chronic pain, but they have been shown to work in some scenarios.

Then the lighter medications -- we call them lighter because they tend not to be the strongest ones for thoughts such as post-surgical pain. That would be the nonsteroidal antiinflammatory drugs such as ibuprofen and naproxen, and then there is acetaminophen.

Q. For the opioids, what are they primarily used for?
A. They are primarily used for a higher level acute pain, such as postoperative pain. They're also used when it is in a situation where that level of pain control is necessary and other medications haven't been successful. A very typical scenario is with severe hip degeneration that occurs within

individuals with sickle cell disease.

Q. You testified to the category of muscle relaxers. Can you please share with us some examples of what you mean by muscle relaxers?

A. Some of the common ones are baclofen or Flexeril. There is quite a few different ones. Even though they're all put in that one category, they actually have different modes of effect and many times we don't exactly know why they might be helpful. For some people who have a disorder that causes muscle spasm, they're more likely to be helpful.

Q. For the anti-inflammatories that you referenced a moment ago, could you please share a few examples of what that might be.

A. So what the medications might be?

Q. Yes.

A. Such as ibuprofen or naproxen. There is quite a few in that category. Some of them have slightly different ways of working. They tend to be a main stage just because they don't have an addiction potential; however, they have other side effects. So sometimes they're not an option for some patients because there are slight differences in the subcategories, if one wasn't useful, another one might be. So for some situations, especially some musculoskeletal situations, it's worth trying more than one.

Q. So would a prescription for ibuprofen be considered part of

a pain management plan?
A. Yes, it would.
Q. What are gabapentinoids?
A. That is a category of medication that is often used with certain chronic pain scenarios, and most commonly with certain types of neuropathies.
Q. Are there any other off-label uses for gabapentinoids?
A. Yes. Well, also, Neurontin can be used as a seizure medication. There are many situations where even though somebody might have a chronic pain condition that is not a neuropathy, there are certain circumstances where it's reasonable to give the medication a try.
Q. You mentioned Neurontin. Are there any other commonly prescribed gabapentinoids?
A. Lyrica.
Q. Anything else?
A. Those are the common ones.
Q. You testified earlier that you stay current on medical literature specific to pain management. Dr. Moores, is there any current medical literature on gabapentin?
A. There is a lot of literature on gabapentin.
Q. What does that literature say?
MS. AGNEW: Your Honor, I'm going to object. I think this is getting into expert testimony.
THE COURT: Ms. Kiley.

MS. KILEY: Dr. Moores testified a moment ago that as part of her -- to uphold her ethical standards, she needs to stay current on medical literature. We know that gabapentin is relevant to this case. So I think I would like to get into some testimony where the medical literature currently stands on the use of gabapentin.

THE COURT: The question is why is this not expert testimony?

MS. KILEY: Because I'm asking Dr. Moores to testify as to what she has read.

MS. AGNEW: Your Honor, no, forgive me, but it is expert testimony. Frankly, it's hearsay about what she has read. We haven't determined the sources of what she's read, we haven't determined how she used them in her practice, we haven't determined if she treated any of the patients that we're here to talk about today. They're trying to bootstrap expert testimony in through a lay witness.

THE COURT: Isn't this testimony based on scientific, technical, or other specialized knowledge; isn't that right, Ms. Kiley?

MS. KILEY: Your Honor, the testimony that I was planning to get into was going to be about the substance of where the current medical literature stands. I was not going to ask for Dr. Moores' opinion on anything, other than to educate the Court on the current status of gabapentinoids.

MS. AGNEW: Right, your Honor, that's the role of an expert.

THE COURT: Rule 702 says a witness who is qualified as an expert by knowledge, skill, experience, training, or education may testify, et cetera, et cetera.

Why is this not that type of testimony? It's not lay testimony; right?

MS. KILEY: No, but Dr. Moores already testified as to all of her background and experience leading up to her position now as the chief medical officer of DOCCS.

THE COURT: Okay. But isn't that based on scientific, technical, or other specialized knowledge?

MS. KILEY: I would think to be a medical doctor, it would have to be.

THE COURT: Therefore, it's expert testimony.

MS. KILEY: It is not being entered for expert opinion.

THE COURT: But it is, is it not?

MS. KILEY: I can withdraw.

THE COURT: Sustained.

BY MS. KILEY:

Q. Dr. Moores, can you please share with the Court a commonly prescribed --

MS. KILEY: Withdrawn.

Q. You testified earlier that there are some antidepressants

that can be prescribed to treat pain. Could you share with the Court some examples of an antidepressant that might be used.

A. Cymbalta.

Q. Given all these options and categories that you've just described, what is your approach when you have a patient who presents with chronic pain?

A. I get history and physical and with primary goal to try to figure out the ideology of the pain. Based on the ideology, it makes it much more likely that the first types of medications that I would choose would be useful and to give me an idea whether or not it's appropriate to consider some kind of procedure, and if they need a referral to a specialist for that.

Q. Is this your approach or would you say this is generally the approach that providers take at DOCCS?

MS. AGNEW: I'm going to object again, your Honor. If she wants to talk about how she approaches doing an assessment of a patient, I'm comfortable with that. I'm not comfortable with her speaking for other providers.

THE COURT: That's right, same rule, specialized technical knowledge. Sustained.

Q. What are some of the factors that you might consider when determining the best pain treatment plan for a patient?

A. The diagnoses.

Q. Does the feedback from a patient factor into a pain

treatment plan?
A. Yes, it does.
Q. How?
A. It's important to know the quality of their pain, what they understand of the diagnoses and the potential risks and benefits of the medication. There is many times where there is more than one option to consider as a next step and their opinion should be considered.
Q. What about the risks associated with certain pain medications?
A. All of the medications have risks, so therefore it's important that that be taken into consideration. If a patient has a contraindication to one of the risks of a medication, sometimes we have to consider not using that medication.
Q. What are some examples of some risks?
A. With NSAIDs, they can be associated with bleeding in the gastrointestinal tract. With acetaminophen, we have to be very careful with the dosing on that. For almost all the other medications, the concern is whether we've got somebody who has a real history of substance abuse and what types of substances they had an issue with and whether or not they have active addictions.
Q. Is there a one-size-fits-all solution for any one particular patient?
A. Not at all.

Q. Why is that?
A. Every single patient who has chronic pain is different. They all have different factors.
Q. And so, could two providers examining the same patient have different views on an appropriate course of treatment?
A. They could.
Q. Could those two different views still be considered appropriate care?
A. Yes.
Q. Why is that?
A. Because unless it's very clear what the diagnosis is, a lot of chronic pain patients have a very complex situation. The options for treating pain sometimes are a little bit of a trial-and-error situation. Therefore, it comes down to the impression of the provider, what they think might be next -- what will be the next thing to try, what would be best to do next with their communication with the patient.
Q. So what challenges, if any, are providers faced with specific to the population at DOCCS when administering pain medication?
MS. AGNEW: Again, your Honor. If she wants to lay a foundation with a policy or something like that, I'd feel more comfortable, but if she's just talking about what other providers are faced with versus what she's been faced with, I'm going to object.

MS. KILEY: I can rephrase the question.

THE COURT: Yes, ma'am.

Q. What challenges are present with the population at DOCCS with the administration of pain medication?

A. We have a few challenges. One is that there is -- because of substance use disorder issues and recreational drug issues within the facilities, there is great pressure to divert their medication and sell it to others, stockpile it, and then we worry that either somebody is going to overdose because they've stockpiled their medication or somebody else is going to overdose who has purchased medication from others.

The other issue is that when we have the patient themselves, if they have a history of an addiction issue, we don't want to contribute to that addiction problem, we want to help keep that under control and move in the right direction so they can work on the programs that they've chosen or that have been set up as being appropriate for them to work towards being effective, especially upon the time they're going to be released.

Q. What is the MAT program?

A. Medication for addiction treatment is specifically for the substance use disorders that wherein the FDA has approved specific medications that can assist with recovery. Our biggest group that uses that program, and we've been expanding it because it hasn't been around for a long time, are those

with a history of opioid use disorder.

Q. How long has the MAT program existed?

A. We have -- for several years, we have taken folks from county jails into reception who were already on methadone. Then, this past fall, we expanded it so that we'll take whichever medication they're on, we'll accept them in. We also have a program within our system where, either by referral from staff within the facility or self-referral by the patient. And also because we also have a list of those who, on entry, did report that they had been using opiates from the street for the year before their arrest, that we assess all of them for potential opioid use disorder and see if they're an appropriate candidate for medication and get them started on medication if that is something that they'd like to do.

Q. What are some examples of those medications?

A. Methadone and buprenorphine products are the most common. We also have naltrexone for opioid use disorder.

Q. So if you have a patient that is in the MAT program that also presents with chronic pain, how does the participation of the MAT program -- how could that affect the decisions in a proper course of treatment?

A. Well, we're considering the medications for MAT, two of them are also pain medications. Methadone and buprenorphine are also pain medications. So they would be preferred for an individual such as that. When we get the medication for MAT up

to the proper dose for their opioid use disorder symptoms, once we're at that point, then we can reassess to see if how much that has helped with their chronic pain situation and what would be -- if anything would need to be added after that. We do have to be concerned about some mixes of medication because opioids, if taken at a high dose, can be risky for overdose and respiratory depression, and some medications mixed together can increase that likelihood.

THE COURT: Doctor, will you tell me again, please, the name of the two medications you made reference to.

THE WITNESS: Methadone and buprenorphine.

THE COURT: Thank you.

Q. How might a patient become part of the MAT program?

A. They can self-refer via sick call. Also, if anybody has an overdose that we treat as an emergency, we will refer them for assessment after they are recovered. The executive team can make a referral. Other faculty -- I mean other facility staff can make referral to the exact team to send to the MAT program. Again, there was a list of about 2500 that, on intake, when they were being interviewed by the guidance intake people, had admitted to using opioids -- opiates in a non-prescribed manner during the year prior to their arrest. So we automatically pulled them in to ask if they would be interested.

Q. Approximately how many patients are part of the MAT program?

A. Right now, we have over 1700, but we still have constant referrals in. I don't know how high our numbers are going to get.

Q. Are there any rules or guidelines for the patients once they are part of the MAT program?

A. Can you clarify.

Q. Do they have to fill out any forms?

A. They don't have to fill out any forms to qualify. If they're asking to be assessed, they just need to do a sick call request saying that's why they want to, that they'd like to be considered. Then they meet with a provider who goes through their history with substance use and goes through the DSM-5 criteria for opioid use disorder.

Q. Earlier you referenced, among the challenges had to do with diverting. So my question is, what is diversion?

A. It's when a patient who comes to a medication line to be administered their medication, and instead of them taking the medication as prescribed and instructed, they hide the medication to do something else with it later.

Q. And in your experience, what do they do with that medication later?

MS. AGNEW: Objection.

THE COURT: Basis.

MS. AGNEW: I think it's hearsay, your Honor, how does she know exactly what they do. The only way she would know is

if a patient told her, and that's hearsay.

THE COURT: Ms. Kiley.

MS. KILEY: She testified that she has experience dealing with pain patients, she has worked with DOCCS since 2016. I'm just asking her collectively, in her experience, when patients are caught diverting, what ends up being the reason as why they've diverted.

THE COURT: Why is it hearsay. That's the question.

MS. KILEY: I can rephrase.

THE COURT: Yes, ma'am.

Q. As a healthcare provider, why would you not want a patient to divert their medication?

A. I would be concerned for their health and the health of the population within the facility based on what we have with emergencies with overdoses, what is found either when cells are searched or when somebody is watching diversion occur, we know it occurs. What I worry about is either that patient is stockpiling the medication to take it all at once or they are selling it to others.

Q. Have patients ever been taken off of a pain medication because they were caught diverting?

A. Yes.

Q. And is it appropriate for a provider to do that under those circumstances?

A. If there is concern for the health risk of that patient or

the population in the facility, yes.

Q. Would that be considered a medical justification?

A. Yes.

MS. AGNEW: Objection.

THE COURT: Ms. Kiley, isn't that expert testimony?

MS. KILEY: No.

THE COURT: It isn't? It's based on medical expertise, isn't it?

MS. KILEY: I'm asking if the chief medical officer thinks it's appropriate --

THE COURT: I know what you're asking. My question is why is that not expert testimony based on this witness's expertise; right?

MS. KILEY: I'm asking based on her professional experience as the chief medical officer.

THE COURT: Scientific, technical, or other specialized knowledge; right? It's obviously expert testimony. Sustained.

MS. AGNEW: Can we also strike it, your Honor, please.

THE COURT: Stricken.

BY MS. KILEY:

Q. Would taking a patient off of a pain medication for diverting be considered a medical justification within DOCCS?

MS. AGNEW: Objection.

THE COURT: Sustained.

Q. Dr. Moores, what is drug-seeking behavior?
A. When an individual makes efforts to get medications that are for recreational or addiction reasons rather than to treat a specific diagnosis from a medical standpoint.
Q. How might you be able to identify that type of behavior?
A. If somebody is found to be inconsistent with their presentation in a medical encounter or if we see that they have made efforts to get medication through other sources.
Q. Did you receive training on this within DOCCS?
A. On?
Q. Identifying drug-seeking behavior.
A. It is something that is discussed during our orientation and on a regular basis with executive team and central office, the executive teams at the facility, and with the programs that treat the substance use disorders, such as the programs for the drug rehab and for our alcohol use disorder programs.
Q. And have patients been taken off of a particular pain medication because of drug-seeking behavior?
MS. AGNEW: Objection. If she wants to testify if she's taken a patient off, I don't have a problem with that.
THE COURT: Ms. Kiley.
MS. KILEY: Your Honor, all of Dr. Moores' testimony is speaking generally as to how providers practice within DOCCS and what is acceptable and appropriate per the professional opinion of the chief medical officer. This is why she's here

today.

THE COURT: Isn't that exactly the problem, the professional opinion of the chief medical officer? That's the point, it's expert testimony.

At the outset of the testimony, you started asking Dr. Moores how chronic pain should be treated, she started out by talking about the diagnosis. This is almost in line with plaintiffs' expert's declaration where he talks about how one assesses a chronic pain. This is clearly expert testimony.

MS. KILEY: Okay.

THE COURT: In Dr. Moores' declaration, she talks about what she did to put together the new policy, her audits, how they're managing it, that she and others are -- I've forgotten what the word is, but a team to review the treatment of chronic pain. I thought that's what she was going to talk about, not how one diagnoses it in this sort of thing.

MS. KILEY: We will be getting to that testimony shortly.

THE COURT: Okay. But the point is she can't give expert testimony if she hasn't been proffered as an expert. You con present the expert disclosures and the like.

MS. KILEY: Okay.

THE COURT: Yes, ma'am.

MS. KILEY: Your Honor, can I take one moment to confer with my team?

THE COURT: Yes, ma'am. Do you want to take five minutes?

MS. KILEY: Please.

THE COURT: Let's take a five-minute break.

(Recess)

THE COURT: Ms. Kiley.

BY MS. KILEY:

Q. Dr. Moores, what was your position in DOCCS in 2017?

A. In 2017, I was the regional health services administrator.

Q. At the time, was there a DOCCS policy in place specific to the admission of chronic pain medication?

A. I can't remember the exact date that the MWAP policy went in, but other than the MWAP policy, the 1.24, there was no policy that was specific to chronic pain care.

Q. And what does MWAP stand for?

A. Medications with abuse potential.

Q. What are MWAPs?

A. There was a list of medication there was linked in that policy, and it was chosen by Dr. Koenigsmann for medications they thought had abuse potential. It was primarily pain medications, but there was also at least one medication for diarrhea.

Q. Dr. Moores, I'd like to show you what is --

MS. KILEY: I'd like to have Exhibit 1 marked for identification.

THE COURT: Are these all marked?

MS. KILEY: No.

THE COURT: Mine are in a binder.

MS. KILEY: It's now under tab 2.

THE COURT: All I was trying to decide was whether we need to go through and mark them. The answer is yes?

MS. KILEY: I believe they're marked.

THE COURT: Why don't you just slap a label on them and mark them so you don't have to go through all the time. It would be different if it were a jury trial.

So it's under tab 2?

MS. KILEY: Yes.

THE COURT: Thank you.

MS. KILEY: May I approach the witness?

THE COURT: Yes, ma'am.

Q. Dr. Moores, do you recognize this document?

A. I do.

Q. What do you recognize it to be?

A. It is the medications with abuse potential policy, 1.24.

Q. Is this a true and accurate copy of the policy that you just testified to that was in place in 2017?

A. Yes. I know that it shows that there was -- prior to this, there was a version that was put in place June 1st, 2017.

MS. KILEY: I'd like to have Defendant's 1 entered into evidence.

MS. AGNEW: I don't have an objection, your Honor, but there was a medication list affixed to this with the MWAP medication. So this version is incomplete. If counsel wants to provide that tomorrow so we have a complete exhibit, I'd appreciate that.

MS. KILEY: I can do that.

THE COURT: Received.

(Defendant's Exhibit 1 received in evidence)

Q. Dr. Moores, is the term MWAP used in the community?

A. No.

Q. Do you know who created this policy?

A. The policy was created, from what I understand, it was the leader to create the policy was Dr. Dinello, who was one of the regional medical directors. From what I understand, it was with discussion with the other regional medical directors and Dr. Koenigsmann who was the Chief Medical Examiner at the time.

Q. Do you know why it was enacted?

MS. AGNEW: I'm going to object, unless she had a role in formulating the policy.

MS. KILEY: My question is if she had personal knowledge as to why it was enacted.

THE COURT: The question is non-hearsay knowledge, isn't that what you mean?

MS. KILEY: I'm not asking for hearsay knowledge.

THE COURT: So that was the nature of the objection.

The objection was, does this witness have personal knowledge of whatever it is.

MS. KILEY: Right.

THE COURT: Okay. Go ahead.

A. Dr. Dinello told me that it was because of overuse --

MS. AGNEW: Objection. Forgive me. She testified under oath that she wasn't a part of this. That's why I'm --

THE COURT: Sustained.

Q. What are some examples of MWAP medications?

A. Oxycodone and -- what else? The gabapentinoids were on there. Now I can't remember the list.

Q. Approximately how many MWAP medications were there, if you remember?

A. I know that the list was on the front of one sheet of paper.

Q. Who decided that those would be the medications designated as MWAP medications?

A. The approval for anything to be on there or for the list to be changed was via Dr. Koenigsmann.

Q. Can you explain, step by step, how MWAP was carried out?

A. You mean as far as what the procedure is that's explained in there?

Q. Yes.

THE COURT: I'm sorry. Could I just interrupt for a moment.

You said how was it carried out, the witness said the procedure. Are you asking the witness to summarize the MWAP procedure?

MS. KILEY: I am.

THE COURT: Doctor.

A. If a primary care provider wanted to prescribe one of the medications that was on that list, they had to fill out an electronic form with what they were requesting and why they were requesting it. That form was sent via email to their regional medical director. The regional medical director then reviewed it and either approved it or denied it.

Q. I'm sorry. How exactly did it get to the regional medical director?

A. It was via email.

Q. How would you describe the role of the regional medical directors during MWAP?

A. They had the authority to approve or deny any of these medication requests and they were the final decision maker.

Q. How many regional medical directors were there at the time?

A. I believe there were four.

Q. Did MWAP pose any challenges to providers?

A. Yes. When a provider had evaluated their patient and decided a certain medication was what they thought was appropriate, sometimes the RMD would deny that medication and then they would have to come up with an alternative treatment

plan.
Q. Why was that a challenge?
A. Because they weren't able to do what they thought was optimal treatment for that patient at that time.
Q. So what was the result of some of the MWAP requests that were denied?
A. There are situations where the provider had to go to an alternate therapy that they thought wasn't as likely to be successful or wasn't as optimal, and then, potentially, the patient suffered as a result.
Q. Doctor, does MWAP still exist?
A. No.
Q. When was it rescinded?
A. In February 2021.
Q. Were you involved in that rescission?
A. I knew of it because Dr. Morley discussed with me and the other RMDs and the health services leadership about -- that that was going to be occurring.
Q. What was the result of the MWAP policy being rescinded?
A. The providers did not have to do a request for these medications anymore to get approval and they could just prescribe the medications.
Q. What was the reaction of the providers after this change?
A. Most of the providers were very happy with that because then they were allowed to do the care that they thought was

appropriate for their patient. There were a few that were not happy with it because they used it as a way to say no to patients where the patient was asking for a medication they didn't think was appropriate and they could then use it as the wall saying, I would love to give it to you, but they're not letting me.

Q. After MWAP was repealed, was a new policy put in place to address chronic pain patients at DOCCS?

A. Yes, the 1.24A policy.

MS. KILEY: Your Honor, may I approach the witness?

THE COURT: Yes, ma'am.

Q. Dr. Moores, I've just handed to you what's been marked for identification as Defendant's Exhibit 2. Do you recognize this document?

A. I do.

Q. What do you recognize it to be?

A. It is the policy we were just talking about, 1.24A, prescribing for chronic pain. That was put in place when the prior MWAP policy was rescinded.

Q. Is the copy you have a true and accurate copy of the policy 1.24A?

A. Yes.

MS. KILEY: Your Honor, I'd like to have Defendant's Exhibit 2 entered.

MR. MORRISON: No objection.

THE COURT: Received.

(Defendant's Exhibit 2 received in evidence)

MS. KILEY: Thank you.

Q. Dr. Moores, what was your position when 1.24A came to be?

A. I was deputy chief medical officer.

Q. Were you involved in the enactment of 1.24A?

A. I assisted Dr. Morley in formatting the policy. He gave me the information, the content that he wanted and he would discuss it with counsel's office and periodically let me know what revisions to make until it was finalized.

Q. Do you know who, besides Dr. Morley, was involved in creating it?

A. I know that there was discussion with the AG's office. I was led to believe by Dr. Morley that Ms. Agnew was part of the choices.

Q. Can you describe in your own words what 1.24A requires?

A. It requires that we identify patients that have chronic pain, that to help keep that identification easy to identify, put it in our patients' problem list and using code 338. It points out that there is no longer an approval process for pain medications unless it's non-formulary, then they have to put in a non-formulary request.

It also points out the specialty consult. When you get the report back, that you make a note in the medical record about anything with the specialist recommendations that you're

not going to follow, that you contact the specialist, if necessary, to clarify details about the patient that the specialist may not understand or have complete information for, and to document your decision-making regarding those recommendations. And that the -- that if a provider is choosing to stop a pain medication, that they should sit down and discuss that with the patient rather than just to stop it and have no conversation. And then finally, with that code, that we make sure that we're seeing chronic pain patients at least quarterly, and that, annually, there be a more thorough assessment.

Q. What would you describe is the main difference between the MWAP policy and 1.24A?

A. 1.24A talks about how to try to organize and manage the administration of chronic pain care. 1.24 just talked about if you wanted to prescribe something on this list of medications, the RMD had to review and approve or deny.

Q. Does 1.24A speak to the RMDs at all?

A. No.

Q. How was this change communicated to providers?

A. There was an announcement memo that was the announcement that 1.24 is rescinded and that they're putting 1.24A in place, and that was sent by email to all of the leadership positions throughout the facilities, the FHSDs, the NAs. When they get announcements like that, they are required to share it with

their providers.

Q. Was there anything else done to facilitate this transition away from the MWAP policy?

A. The 1.24 request form, the online electronic form and the process of that going through central pharmacy, that was removed.

Q. I'm sorry. Can you repeat what was removed?

A. The online MWAP request form that the provider had to fill out if they wanted to prescribe one of those listed medications, that then went to the RMD for approval or denial.

Q. So even if a provider wanted to try to fill out an MWAP form, would they have been able to?

A. No.

Q. As you sit here today, do the regional medical directors still review MWAP requests?

A. No.

Q. Is there a system in place that would allow an RMD to deny the patient the right to receive the treatment that they're being prescribed?

A. No.

Q. Are you aware of any providers who are still trying to follow the MWAP policy?

A. No.

Q. I want to go through each part of 1.24A very briefly.

You mentioned the 338 code. Dr. Moores, what is the

medical problems list?
A. It is within the part of the medical record, which is electronic on what is called our FHS1 system in our mainframe. We have a list of potential codes for conditions or certain treatments that get done, such as vaccines. So that is something that's available to all the healthcare staff to look at, at any given time, and we can run some reports off of it.
Q. What is the purpose of the medical problems list?
A. So that anybody who is referring to that patient's situation can hopefully see, in a nutshell, the main things that that patient has as acute and chronic conditions.
Q. In your experience, is the medical problems list helpful to providers?
A. It is.
Q. Was the medical problems list intended to track symptoms?
A. No.
MS. AGNEW: Objection.
Q. What is the purpose of the medical problems list?
A. It is to list the diagnoses that a patient has.
Q. What does 338 stand for?
A. For pain management.
Q. Is pain management a diagnosis?
A. No.
Q. Then what is pain management?
A. Pain management, that code is a tool to use to be able to

run reports and follow whether or not their frequency of care meets the criteria within the policy.

Q. Are there any other codes besides 338 that track symptoms?

A. That track symptoms --

THE COURT: I thought the witness said that 338 doesn't track symptoms, rather tracks diagnosis.

THE WITNESS: 338 actually is just -- it tracks if there's a patient that needs pain management. So we generally don't consider pain management as a diagnosis, but having that on that problem list can make it easy for us to pull reports to say that patient needs to be seen this often. Usually, when we do that, we'll do it off of diagnosis.

THE COURT: Thank you.

Q. Since becoming chief medical officer, have you come to learn that there are still patients that have chronic pain that might not be coded with 338?

A. Yes.

Q. If those patients don't have the 338 code, are they still being treated for pain?

A. Yes.

Q. Does the presence of a 338 code dictate what course of treatment a patient's going to receive?

A. No.

Q. The next section of 1.24A you mentioned earlier says that the only type of medication that needs approval are those on

the non-formulary list. So my question to you is, what does it mean for a medication to be on non-formulary?

A. We keep a formulary that includes medications from almost all common categories of medications that are used in the community. The reason there's a formulary list is because there are so many thousands of medications, and even in some of those categories, the number of choices is tremendously high. So we have certain ones that are common and that's on the formulary. But that doesn't mean there might not be situations where somebody should be considered to get a medication that's not on our formulary, and that's the non-formulary process. The most common medications that come through that are some of the newer, more novel and more expensive chemotherapy agents for cancer, and some of the newer medications for rheumatological diseases.

Q. How might a provider know what medications are on formulary versus not on formulary?

A. There is a published formulary, and that's available for them to refer to. There are periodic memos for additions in between the regular publications. Then, periodically, somebody will put in a non-formulary request for a medication that actually got on the formulary and they didn't have the most recent version of the formulary, and then we'll let them know that wasn't required, they can just order the medication.

Q. Are the MWAP medications that you testified to earlier

today, are those on formulary or not?
A. I believe the great majority are on formulary. I know that gabapentinoids got on there. We very rarely, because I do a good portion of non-formulary reviews now, it's very rare I'll end up having something that is specifically a pain medication. I did get one, like the other day, which was for gabapentin, but it was for a dose that we normally don't keep around, but it made sense to do it for that patient, so that was approved.
Q. When 1.24A was first promulgated, who approved the non-formulary requests?
A. The RMDs.
Q. Has that changed?
A. Yes.
Q. Why did that change?
A. When I was officially placed into the chief medical officer position, I started doing audits of what the RMDs were doing, and I found that my that audits had been on formulary review on denials they had done, and there were situations where their denials were for medications that were to treat a chronic pain condition and I didn't agree with their reasoning. So I just chose to just take them off that review process.
Q. How did you do that?
A. I took away their access to that system. I changed where -- there are only, including myself, five of us that I think -- me plus four other physicians that I believe are very

knowledgeable, very sophisticated, and have a very good communication base so that if they see that there's a medication request on there that might not be optimal, they reach out to the provider, they'll see the patient with them if necessary and make sure the right thing is done for the patient.

Q. How were you able to ensure that the RMDs were no longer part of the non-formulary review process?

A. Their access to that system was removed. Those requests go to a shared mailbox and they no longer can access that mailbox.

Q. How did you communicate this change to the regional medical directors?

A. Via email, and they were also told over telephone.

MS. KILEY: Your Honor, may I approach the witness?

THE COURT: Yes, ma'am. I don't think you have to ask. I don't think the doctor is worried you're going to leap over the stand.

MS. KILEY: This will be behind tab No. 5.

Q. Dr. Moores, I've just handed to you what's been marked defendant's 3 for identification. Do you recognize these documents?

A. Yes.

Q. What do you recognize them to be?

A. So the top one is an email from me with the primary individuals that it was going to, are the three RMDs that were

in place at the time, and then copied to my top leadership from health services.

The second one is the memo on October 31st, which served to give a reminder about 1.24A and the specific pieces within that policy that need to be adhered to, a reminder for the providers. That went to the deputy superintendents that oversee health services at the facilities, the facility health services directors, and the nurse administrators.

Q. And are these documents that you've just described, were they drafted by you?

A. Yes.

Q. And are these true and accurate copies of the emails and memo that you put out to describe the change that you just testified to?

A. Yes.

MS. KILEY: Your Honor, I'd like to have defendant's 3 in evidence.

MS. AGNEW: No objection.

THE COURT: Received.

(Defendant's Exhibit 3 received in evidence)

Q. Dr. Moores, since you've made this change for the non-formulary review, have the RMDs inserted themselves into the process?

A. I saw one incident where, potentially, that person could have. One of the RMDs was notified about an unusual

non-formulary request, meaning that it had been approved, but the situation was that this medication, which is an injectable medication, needed to be injected by a specialist, an orthopedic surgeon because it's an expensive medication and sometimes our patients will refuse the trip or the procedure at the last minute, he didn't want to be ordering the medication at his office and find out the patient wasn't going to come and that he wouldn't get paid for it. So we agreed to arrange to order the medication for him. So I had to go through our process and our purchasing because it was unusual and a little bit more expensive.

One of the people who ended up being involved with the budget review misunderstood what was going on and sent it on to one of the RMDs who then emailed back to several people saying this specific medication was denied by Dr. Morley in the past, maybe this needs to be reviewed by others. So I made sure that the medication was ordered and that she and the others who were not following protocol were removed from the process so that that medication was taken care of. That RMD was counseled on this immediately and afterward, counseled on other things. This RMD is no longer doing RMD work.

Q. Are any of the commonly prescribed pain medications that you've testified to earlier today, are they on the formulary or not?

A. Formulary.

Q. What are the circumstances under which someone, other than the provider, would be making a decision on a prescription?
A. Only with a non-formulary process.
Q. I want to move on to the section on 1.24A that talks about your recommendation of a specialist. Dr. Moores, are any of the providers at DOCCS pain specialists?
A. No.
Q. What might a patient receive in pain management that they cannot receive from a provider at DOCCS?
A. A pain specialist can provide a more sophisticated and knowledgeable evaluation and treatment plan and offer procedures that we cannot offer.
Q. Are specialists able to prescribe DOCCS patients medication?
A. No.
Q. Why is that?
A. The way the policies are set up within our system, the orders for medications and the orders for administration of medications have to come from our own providers. So, therefore, when a specialist recommends things, the primary care provider has to review and implement those recommendations, which would include orders for medication as opposed to in the community, if you see a specialist, they can prescribe for you, you can go to the pharmacy and pick it up despite what your primary care provider would agree to or not

agree to.

Q. What do providers generally do when they receive a recommendation from a specialist?

A. They generally implement all the recommendations.

Q. In the community, do providers always, 100 percent of the time, follow the recommendation of a specialist?

MS. AGNEW: Objection.

THE COURT: Sustained.

Q. What are some reasons that a provider might not follow the recommendation of a specialist?

A. If they realize that, for example, a medication order may have significant risk for that patient or interaction with other medication. If their recommendation has a security risk, such as a brace that has a lot of metal in it which can be used inappropriately in that setting. Also, if the patient actually is not interested in following that recommendation.

Q. Are those circumstances you just described, would that be appropriate?

A. Yes.

Q. During this litigation, have you had the opportunity to review specialist recommendations?

A. I have.

Q. Approximately how many?

A. I don't know. I review specialist recommendations regularly in addition to the reviews for this case. I

regularly end up with other cases coming across my -- other patient cases coming across my desk because of issues somebody has identified, whether it was the patient themselves reaching out or a healthcare staff or an advocate for the patient from outside our agency. So it's hard for me to recall that. I look at these types of records all of the time. That is one of the things that is concerning to me is that the specialist is making recommendations and the primary care provider is not following that and that, to figure out why, whether it makes sense, and if I have a provider who's doing that on a regular basis.

Q. And to the extent you haven't been able to figure out the "why," what have you done to determine the rationale for not following a recommendation?

A. If it's not in the record as it's supposed to be, I'll reach out to the facility or I'll have somebody reach out to the facility to get that information and see if there's a -- if there was a misunderstanding, if there was a missing-knowledge base, if I have to arrange for somebody else to see the patient.

Q. In these scenarios that you've just described where it was unclear from the record and you, yourself, had to follow up with the provider, have you found out that any of the reasons for not following the specialist's recommendation were for nonmedical reasons?

A. Yes. Well, there are situations where the patient actually has told them that they didn't want a certain recommendation to be implemented. Then there's concerns about security, but that's not an issue with -- that doesn't come up with medications, that comes up more with durable medical equipment and what can be allowed to be in a cell.

Q. In the times where you've come to learn that it's the patient that doesn't want a medication anymore, why might that be significant?

A. Well, it's important to know if a patient does not want something and that we take that into consideration with a treatment plan and then adjust the treatment plan. It's important to be able to discuss with the patient what the risks and benefits might be to stopping that medication or considering a different treatment option. Finally, since an awful lot of these medications have to be one-to-one and there's a decent amount of workload with setting those medications up with each of the med lines at least twice a day for many things, and that nursing needs to go through all of that process and get it ready and document what occurs, security has to call the patient out. If we know that the patient has shown that they want to stop taking a medication, we want to stop the order as soon as possible in order to be more efficient with the care that we give.

Q. Is stopping a medication because a patient has orally

communicated that they don't want to take it anymore, is that appropriate?

A. It is reasonable to do that.

Q. The piece in 1.24A that speaks to documenting or reason for not following a specialist recommendation, is documenting the reason behind a treatment plan, is that something new to DOCCS?

A. No.

Q. And how long has that -- can you explain?

A. We have another policy that talks about specialty care, and that when a specialist report comes back, the provider is supposed to review that report and document in the record about what the diagnosis and recommendations were and what the plan is. That policy was in place before the 1.24A.

Q. Do you expect the providers at DOCCS are to document every single word exchanged between the provider and a patient during every encounter?

A. No.

Q. Why not?

A. That it wouldn't be reasonable if we keep a transcript of absolutely everything, it would be too time consuming, and that's not expected in standard care medicine to write every single word.

Q. If every single thing is not documented, does that necessarily mean that the patient hasn't received adequate care?

A. No.
Q. To confirm, who was the individual that decides whether or not to follow a specialist's recommendation?
A. The primary care provider.
Q. Are the regional medical directors involved in that process?
A. No.
Q. I want to talk about the final piece on 1.24A that talks about followup appointments every 90 days. Is a followup visit every 90 days appropriate for a pain patient?
A. It would depend on what the diagnoses are for that patient and how well things are stabilized.
Q. How does this compare to followup visits in the community for pain?
MS. AGNEW: Objection.
THE COURT: Sustained.
Q. How often are pain patients at DOCCS seen?
A. The primary provider taking care of the patient would make the decision. There are some situations with chronic pain patients where we would want to see them much more often than that. There are some that are very stable and they feel comfortable with how to access the system if they have exacerbations in between and they would be seen less often.
Q. If a patient believes they need to be seen before their next scheduled appointment, are they able to see a provider?

A. They can put in a sick call request.
Q. What does that mean?
A. The sick call requests get triaged, anything that looks emergent or that security thinks is emergent gets taken care of immediately. Otherwise, the nurses triage then and they'll be seen -- most commonly seen in sick calls and the nurse can take the information and do whatever part of the assessment that the nurse normally does, decide whether or not they need to be seen by a provider, and then set that up as needed.
Q. Typically, after a patient puts in a sick call slip, generally, how long does it take for them to see a provider?
A. That can vary depending on what the complaint is and the facility. So there are times, like when I was working as a provider in a facility, I had a setup where if the nurse needed them seen the same day, they were seen the same day. There were other ones where they knew it was just a routine item, they would put in a referral within our appointment system to be seen. Most places, they'll get seen within a few days to two weeks. And it depends on the staffing.
Q. If a patient was not scheduled for a 90-day followup visit, are they still able to see a provider?
A. Yes.
Q. And how would they do that?
A. Via the sick call system.
Q. Finally, I want to talk about the annual evaluation

referenced at the end of 1.24A. 1.24A requires a provider to, quote, discuss at least annually a patient's treatment plan.

MS. AGNEW: I'm just going to object to the characterization of what the policy says, because that's not what it says.

THE COURT: Are you making reference, Ms. Kiley, to the last bullet point on the first page of the October 31, 2022 memorandum?

MS. KILEY: No, I was referring to the last line of 1.24A. I was just summarizing what it says.

THE COURT: Why don't you just say with respect to that line, and go ahead and ask your question, please.

MS. KILEY: Yes. I will withdraw the question.

THE COURT: Yes, ma'am.

BY MS. KILEY:

Q. Dr. Moores, is the term "reassessment" used in the community?

MS. AGNEW: Objection.

THE COURT: Sustained.

Q. Dr. Moores, 1. 24A requires an annual evaluation, what is your understanding of an annual evaluation in this context of 1.24A?

A. Well, the sentence says that at least annually, the primary care provider will meet with the patient to discuss the proposed treatment plan, but we don't have anything specific,

like as far as forms go or details, regarding what that has to include.

Q. In the community, how might an annual evaluation be conducted?

A. It would depend what the annual evaluation is for. You mean for chronic pain?

Q. Yes.

A. I'm not sure if there is something they call an annual evaluation for chronic pain. I think generally they, at least what I've seen with the pain specialists and what they recommend and what they write is that they see the patient do the evaluation and treatment plan they come up with. Then as far as how often they follow up depends on their impression and what they would like to do. Sometimes it's more often and sometimes it's less often, but every single time they do a treatment plan on some level.

Q. Is discussing a treatment plan something that would come up in a routine visit?

A. Yes. Every time you see a patient, you're evaluating them for some issue or multiple issues, you are going to have a treatment plan.

MS. AGNEW: Objection. Dr. Moores may have a treatment plan. She can't testify as to what every provider does.

THE COURT: And that's right; isn't that right,

Ms. Kiley?

MS. KILEY: Yes.

Q. Dr. Moores, are the regional medical directors involved in the annual evaluation process?

A. For the pain, the requirement for this policy?

Q. Yes.

A. No.

Q. Is anyone, other than the provider, conducting an evaluation?

A. No.

Q. Would the presence of a form and a formalized evaluation process, would that change the provider's ability to prescribe pain medication?

A. No.

Q. Does the lack of a form mean that a patient is not getting the treatment that they need?

A. No.

Q. And if a patient believes that they're not receiving proper treatment for pain, is a formalized evaluation going to resolve that issue?

A. No.

Q. Why not?

A. Because it still comes down to what that provider's personal opinion is about the diagnoses and appropriate evaluation and treatment for that patient, regardless of what

form they might put the information on.

Q. Dr. Moores, I want to switch gears now and touch on briefly some of the audits that you describe in your declaration.

In your career, have you had experience with auditors specific to a medical organization?

A. Yes. I was involved with quite a few audits at hospitals and outpatient clinics by the Joint Commission of Accreditation, is one of the main accreditors of hospitals, and also have other audits from a variety of organizations that would come to audit within healthcare settings.

Q. What is the purpose of an audit?

A. To check whether or not -- in general, it's to check whether or not standards are being adhered to.

Q. Are audits of medical organizations and clinics standard practice in the community?

A. Yes.

Q. In your experience, is it customary that an entire health services staff has 100 percent compliance with all policies?

A. No.

Q. And the audits that you've described in your declaration, are some of them new to DOCCS?

A. Yes.

Q. Which ones?

A. The audits that we have initiated specifically for the policy 1.24A.

Q. Can you briefly describe how you are auditing 1.24A?
A. Our SURN unit — SURN is for senior utilization review nurse unit — they regularly do audits at our facilities to check on a number of standards and policy adherence. So they have started this and were continuing to expand what it is they audit and how they audit. The key pieces of this that are objective are what we're trying to look at, whether or not the 338 code is being used. If someone has a 338 code, are they being seen at least according to the time requirements listed at the bottom there. If they get a specialty referral report back, have they documented what they did with those recommendations. So things like that are the main issues.

Figuring out whether or not they have put the 338 on can be challenging because if the 338 is not there, how do you look to decide which ones would you check? So, in addition to doing some random chart looks, they also are looking at other diagnoses that are on problem lists already that you know the likelihood if somebody has low back pain, the likelihood they have chronic pain is very high. So those are examples of what they can pull reports of with a number of other diagnosis codes that we know of where we really should be looking to see is that person a chronic pain management patient.
Q. You testified that some of these components are objective. So my question is, is there anything about the 1.24A audit subjective?

A. No, it's basically looking for the 338, are they being seen in time, are they documenting when the specialist report comes back and putting the correct details in place, and also to look at the situation about when medications are stopped and are the appropriate documentation items in place for that, also.

Q. In your experience, is the audit that you've just described for the Court today any different than what an independent auditor might do for DOCCS?

MS. AGNEW: Objection.

THE COURT: Sustained.

Q. Dr. Moores, if you come to learn that a patient is complaining that they haven't received effective medication to treat their pain, what obligation, if any, do you have?

A. I have key people look into the situation by talking with the healthcare staff there, by getting copies of the medical record and reviewing the medical record, and pursuing through those avenues. Sometimes it's because there's a communication drop in that there needs to be more information given to the patient. Sometimes there is something that needs to be addressed further and we'll arrange for that. Sometimes a patient is asking for a medication that's not appropriate for them, but that still needs to resolve in communication with the patient.

Q. And in these circumstances where you've come to learn that a patient is complaining of pain, can you call the provider and

order them to order the medication that the patient is asking for?

A. No. Ethically, it's not appropriate to ask another provider to just order a drug. It has to be the case where the person who's ordering the medication has done the assessment and treatment plan for the patient and is ordering what they believe to be appropriate.

Q. What do you mean by, ethically, you can't do that?

A. I cannot order somebody to prescribe a medication that they don't feel comfortable with for the care of a specific patient that they've been seeing. If I have a situation like that where I -- with the information I have about a patient where I am suspicious that maybe another medication should be strongly considered for a patient, but I'm not seeing the patient, then there are some different things that can be done. I can discuss with the provider to see if there is a piece of information that I don't have that would make this logical or is it a situation where I might be concerned that that provider maybe doesn't have the optimal knowledge base and experience to take care of that patient and something else should be considered.

So it could result -- just talking to that provider on the phone doesn't resolve the problem and I still have questions, it can be resolved by either arranging the patient be seen by somebody else or having that provider's work

reviewed to see if it is competent in that scope of practice.

Q. Going along with the circumstance where you find that a patient is complaining that they haven't received effective pain medication, do you consider this an emergency circumstance?

A. Not unless there is something that is giving information that makes me think it requires an emergency room or there's something that's going to immediately require a procedure or immediate imaging study that something could be life-threatening, that could threaten a loss of limb, those I treat in an emergent manner.

MS. KILEY: Your Honor, could we take a five-minute recess?

THE COURT: Sure. Thank you, counsel.

(Recess)

THE COURT: Inquiring minds want to know how we're doing with this witness?

MS. KILEY: We're almost wrapping up, so I would say 15 minutes.

THE COURT: Cool. We have a 1 o'clock, I think. When you see 12 people and they're ready to go, why don't you stop.

Won't you be seated.

Ms. Kiley.

MS. KILEY: Thank you.

BY MS. KILEY:

Q. Dr. Moores, can you please describe the process of when an incarcerated individual transfers from one facility to another, from the medical standpoint?

A. Their medical records are supposed to go with them. Sometimes their medications go with them, sometimes not. There's different rules for that, the situation, based on what pharmacies are where. However, the one key piece is that our policy is such that the orders for medication, the orders for administration of medication have to come from a provider who's assigned to that facility. So, therefore, when they move to a new place, the orders have to be restarted, they need to be reviewed and restarted. The nurses are not allowed to go on orders from the last facility.

Q. Why is that?

A. That is how our policy is set up.

Q. You believe you testified that there are certain circumstances when medications will travel with the patient and sometimes they do not. So can you explain the circumstances when medications do travel with the patient?

A. Most commonly, it's when they're what we call keep on person medication where they can be prescribed, just like when we get medication from a pharmacy, the bottles of medication are dispensed directly to the patient and they're kept in their cell and they'll be transported with their cell belongings. There are sometimes medications which are one-to-one, meaning

that they have to be administered by a nurse and they have to come to the medication line for that medication. Some of those medications will also accompany the patient and some of those medications will not.

Q. At what point in the intake process will a patient be physically examined?

A. For those that come into reception -- so they've come from a county jail or Rikers -- within the first few days that they're there, they'll have a history and physical. However, immediately, within 24 hours of being there, a nurse will do a quick assessment with them to see if there's anything acute going on.

Q. Are there any rules or guidelines as to when in that timeline any new medications should be ordered?

A. The medications, for example, for reception, generally, we do get medication lists from the county jails prior to the arrival of the individual, and when everything goes right, we have that medication far enough ahead of time that the providers can review those lists and start the orders. There are times where the provider will just order everything, there is times where they'll substitute something because they know there is a similar medication that is easier -- has easier availability for us, for example, that it's formulary and is basically the same category of medication. Then there's times where the provider will decide to wait until they see the

patient and have a chance to review everything before continuing that medication or deciding what is going to happen with that issue.

Q. Is it appropriate if a provider at a new facility makes a clinical decision not to reorder every single thing that a patient was on at their prior facility?

MS. AGNEW: Objection. The characterization as appropriate. If she wants to say it conforms to a policy, I think that's okay.

THE COURT: Sustained.

Q. Are providers expected to order everything from a medication list from a prior facility?

A. No, providers are expected to use their judgment.

Q. What do you mean by use their judgment?

A. To look at that list, look at the information that they have, make a decision about what absolutely has to continue, what the timing of that is, whether they would prefer to see the patient first, and those are the kind of things that they would consider when they're looking at which medications to order immediately.

Q. And in any of those scenarios, do you have any reason to believe that medications that might not be reordered at a receiving facility are because the provider believes that the MWAP policy exists?

MS. AGNEW: Objection.

A. No.

MS. AGNEW: It calls for speculation as to why the provider may or may not prescribe.

MS. KILEY: Your Honor, I'm asking if she has any, based on her personal knowledge, if she knows if there are any providers making decisions based on the MWAP policy.

THE COURT: Can you answer that one, please, doctor.

A. No.

THE COURT: Thank you.

Q. Dr. Moores, are the regional medical directors involved at all in the administration of pain medications to patients at DOCCS?

A. No.

Q. How are you able to ensure that the practices of the RMD involvement under MWAP are no longer taking place?

A. We moved the MWAP request procedure and removed the RMDs from the non-formulary request procedure.

Q. Will DOCCS ever go back to the MWAP policy?

A. No.

MS. AGNEW: Objection.

THE COURT: Basis.

MS. AGNEW: Calls for speculation. She can say what she would do. She can't say what a chief medical officer ten years from now would do.

THE COURT: Do you want to try that again, Ms. Kiley.

Q. Dr. Moores, would you ever bring back the MWAP policy?
A. No.
Q. Why not?
A. Because the way that it's set up, it's not -- it wouldn't perform what I believe the intent was. Although, it's really very typical and considered appropriate oversight to pay attention to whether or not you have providers that are overprescribing certain medications --
MS. AGNEW: Objection.
THE COURT: Sustained. It's clearly expert testimony.
Q. Dr. Moores, since you've taken over as chief medical officer and based on all of your auditing that you've described today, what, if anything, stands between a provider and their ability to prescribe pain medication?
A. Only if it's a non-formulary medication, then it has to go through review by one of the five individuals, including myself.
Q. And if it's a formulary medication?
A. They can order anything off formulary.
MS. KILEY: I have nothing further.
THE COURT: Thank you.
Do you want to start a little cross?
MS. AGNEW: I can, but it's going to be extra and I'm going to have to hand out everything.
THE COURT: All right. All right.

MS. AGNEW: I'm sorry. Just being honest.

THE COURT: 2 o'clock, friends.

Anything else on the record, friends?

MS. AGNEW: Not right now, your Honor. Thank you.

THE COURT:

(Luncheon recess)

AFTERNOON SESSION

2:05 p.m.

THE COURT: Thank you, friends. Won't you be seated.

Come on up, Dr. Moores. You don't get off that easily. And I'll just remind you you're still under oath.

Ms. Agnew.

CROSS-EXAMINATION

BY MS. AGNEW:

Q. Good afternoon, Dr. Moores. As we get started here, I want to turn your attention to the exhibit that was already admitted as D2, and I think I put it right back up there for you.

A. Yes.

Q. Do you see that?

A. Yes.

Q. One of the elements of 1.24A that your counsel didn't go over with you shows up right under the bullet point, do you see that about three quarters of the way down the page?

A. Yes.

Q. Can you just read to me the first sentence of the paragraph following the bullet points.

A. Pain management medication should only be discontinued after provider has met with the patient --

THE COURT: Doctor, see this gentleman in front of you, he's taking down what you're saying. So go a little more slowly when you're reading, please.

A. Pain management medication should only be discontinued after provider has met with the patient, discuss the issues regarding the use of the medication, analyze the patient's situation, and subsequently determined that it is in the best interest of the patient for the medication to be discontinued.
Q. The next sentence, can we agree, says the discussion with the patient and the reason for discontinuation of the pain medication will be recorded in the AHR; correct?
A. Yes.
Q. Do you see a carve-out there for transfers?
A. Do I see any mention of transfers?
Q. Is there an exception in policy 1.24A when a patient is transferred to the policy that a provider must seek down before discontinuing pain medications?
A. I don't see any reference to doing things differently with a transfer.
Q. Let's start to go over your testimony that you gave earlier. You talked about a chronic pain assessment, correct, as part of 1.24A?
A. I may have discussed about what is in the last two sentences.
Q. And does that say that there should be a chronic pain assessment?
A. It says that patients with pain management designation code 338 will be seen at least every 90 days by a PCP, and code 338

above is designated for pain management.
Q. And then I believe earlier you discussed the document that's marked as D3; correct?
A. Yes.
Q. And can you look at the second page of D3.
A. Yes.
Q. That's a memorandum from you; correct?
A. Correct.
Q. And it's dated October 31st of 2022; correct?
A. Yes.
Q. And you sent it to the deputy superintendents for administration and health, the facility health services directors, and nurse administrators; correct?
A. Yes.
Q. Did you send it to facility providers?
A. Not directly.
Q. What do you mean when you say not directly?
A. When memos and announcements come to an FHSD, they are supposed to get it to all of their staff.
Q. When you say they're supposed to get it to all of their staff, how do you, as the chief medical officer of DOCCS, ensure that each member of a facility's medical staff reads one of your memos or policies?
A. I don't have a way to ensure that.
Q. So when you sent out this memorandum, I think you testified

you did it via email; is that correct?

A. Correct.

Q. Did you have anyone call each facility or did you do it yourself and ensure that this memorandum was, in fact, distributed throughout the medical staff?

A. Nobody called the facilities about this memo.

Q. But isn't it true that at the facility level, there is a verification form that providers can sign when they go over a policy, and they all sign it and they get a little credit for it?

A. I assume you're thinking of the RTF, which is a record for training form, and that is used when there's trainings.

Q. Isn't it true that in DOCCS medical, there are trainings on policies?

A. Sometimes, yes.

Q. So isn't it true that when you distributed this memo, you could have also said let's have an RTF, and you could have had every member of the medical staff at a facility verify that they had, in fact, read your memo?

A. That would be an option.

Q. And you didn't do that; correct?

A. Correct.

Q. And now let's look at the content of this memo at the last part, at the bullet point, you see at least annually, patients must receive an individualized assessment to evaluate their

general treatment plan for that chronic pain syndrome, an individualized assessment must include; is that correct?

A. That's correct.

Q. Isn't it true this memo was intended to offer interpretation to the facility providers on the ground?

A. It was intended to give them detail of what is reasonable to expect for an annual assessment.

Q. And when you submitted a declaration to this court with the opposition papers, isn't it true you also delineated what you expected in an individualized assessment?

A. I would have to know which part you're talking about and look at it.

Q. Sure. So I've pre-marked your declaration up there, it says P32.

MS. AGNEW: Your Honor, I'm no the going to move it into the record because it's already there, it's docket No. 489.

THE COURT: Yes, ma'am.

Q. Dr. Moores, if I could direct your attention to paragraph 21 on page 5, and just take your time finding that.

A. Yes.

Q. Have you found it?

A. Yes.

Q. Great. So in paragraph 21, isn't it true you defined what an annualized individual assessment should be for the Court?

A. I did define details of what an annual individualized assessment should include.

Q. And when did you offer training on what an annual individualized assessment should include to your facility providers on the ground?

A. I have not offered that training.

Q. I want to talk to you for a moment and offer some clarification on non-formulary drugs. I think you testified earlier that non-formulary drugs are those that are not kept in stock in the facilities or in the pharmacies; correct?

A. That's not correct.

Q. Could you please tell me the difference again?

A. Non-formulary medications are those that are not on formulary, but stock medications are medications that certain facilities can keep in stock. There are also other facilities that have pharmacies and then they can have additional items that are kept on the shelf there. So, all stock meds and, also, additional medications are on formulary. Non-formulary is if it's not listed in our formulary or our memos that have updated the last formulary, and those would be non-formulary medications.

THE COURT: I'm sorry. I'm confused. Formulary, non-formulary, just means on the list, off the list; right?

THE WITNESS: Correct.

THE COURT: And stock medications can vary from

facility to facility, that is what they keep in stock?

THE WITNESS: Correct.

THE COURT: Is that right?

THE WITNESS: Correct.

THE COURT: But all of them will be formulary?

THE WITNESS: Correct.

THE COURT: Thank you.

Q. So just to kind of clarify the distinction a little bit more, it could be true that there are non-formulary medications stocked; correct?

A. No.

Q. Forgive me.

THE COURT: Let me try it differently.

A non-formulary medication could be in the facility if it was ordered specially for someone, but it would not be stocked in the ordinary course?

THE WITNESS: Correct.

Q. But isn't it true, Dr. Moores, that Lyrica, for instance, is a non-formulary drug?

A. I would have to reference my formulary to see which of the pregabalin and which of the gabapentinoids are on our formulary, which dosings, and I was under the impression that Lyrica was on our formulary, or at least one form.

Q. Are controlled substances on the formulary?

A. There are some.

Q. Isn't it true that Lyrica is a controlled substance?
A. Lyrica is not considered a controlled substance in our setting.
Q. What's the distinction between your setting and the FDA?
A. Well, it's not a federal controlled substance. It is controlled in some states. Wait. It may be on one of the schedules.
Q. You may be confusing Lyrica and gab pen tin.
THE COURT: Ladies, you can't talk over each other. The court reporter is able to take you both, but it is hard.
Q. You testified earlier that all medications have risks; correct?
A. That's reasonable.
Q. And you talked about when you, I think, are doing a kind of workup about the risk benefit analysis of a medication, though you didn't use that term, that you might consider whether or not the patient has an active addiction; is that correct?
A. Yes.
Q. And what do you, as a provider, consider to be an active addiction?
A. Based on the criteria in the DSM.
Q. And do you know that criteria sitting here today?
A. It's long.
Q. Is there some kind of temporal range for active addiction, like how long the user last used the drug?

A. In the DSM, they do make that -- it's one of the criteria that they do consider. However, there's also situations where we'll get the diagnosis from OMH, and also to consider that just because somebody has not had access to a drug for a while doesn't mean that they don't have a substance use disorder, they may not have been active recently.

Q. In your knowledge as chief medical officer of DOCCS, is there a way to test patients for whether or not they've used the substance very recently?

A. It depends on the substance, but for most opioids, yes.

Q. Isn't it true you could also test for gabapentinoids? Or let's say gabapentin in particular.

A. Yes.

Q. Do you know whether or not, since you've been the chief medical officer, you've provided any training to your facility providers on how to calibrate whether or not a patient has an active addiction?

A. I have only made sure that they had access to the DSM-5 criteria. That has been it. They also can access -- they can consult with OMH professionals and Oasis professionals.

Q. That wasn't my question, though. I'm asking, since you've been the chief medical officer, have you arranged for there to be training of facility providers of how to make an analysis of whether or not a patient has active addiction?

A. No.

Q. Tell me this, in your role as the chief medical officer of DOCCS, have you made any efforts to pull data on diversion of medications?

A. No.

Q. In your role as the chief medical officer of DOCCS, have you made any efforts to call data on active abuse among the patients within DOCCS?

A. No.

Q. You also talked, I think, for a little bit about the MAT program, and that's M-A-T?

A. Yes.

Q. Are there currently backlogs of getting patients into the MAT program?

A. We did have a backlog for a little bit because of an issue with supplies of buprenorphine, but we're catching up on that now. We've added other pharmacy sources for getting the medication and have added sublocade, also, as another option.

Q. You just testified that you're catching up; correct?

A. Correct.

Q. Are you caught up or is there still currently a backlog?

A. I believe that there will be a backlog for a while, and the reason being that we just started the process, and initially, we only had a certain number who were asking for it. We continue every single week to get more requests to join the program.

Q. I think you testified earlier that the MAT program is an option for some providers who want to treat chronic pain in their patients; correct?
A. Correct.
Q. Are you aware of instances where instead of immediately treating the patient, the provider is trying to get the patient into the MAT program, which has a backlog?
A. If a provider has already seen the patient and assessed them, they can start them. The only backlog has to do with if somebody put in their request through sick call and then they get put into the referral system to be added to the assessment clinics, but if the provider's already assessed them and realizes what they need to have or what they're going to recommend, they can start the medication.
Q. So if I understand your testimony, the backlog is with the assessments; correct?
A. Correct.
Q. How are you tackling the backlog in assessments?
A. I have a staff in central office who have been working with each of the facilities to look at the backlogs and figure out what might be getting in the way. We've had a couple of providers who have seen patients for other facilities to come in to get the assessments done.
Q. So it sounds to me like you're resorting staff; would that be correct?

A. I don't know what you mean by resorting.
Q. I apologize. Reassigning staff.
A. They're not reassigned. They're just temporarily going to get the assessment done for a facility and making the initial treatment plan.
Q. Are you familiar with the process for assessing a patient for participation in the MAT program?
A. Yes.
Q. And can you describe that process for the Court.
A. They meet with a provider who then goes through at least a form, has them answer the main pieces of the DSM-5. They can also choose to ask other questions during the interview process and they can also choose to request medical records from prior places where they've been treated. They can also request to discuss with OMH, if OMH has been involved with a patient, and to check with guidance to see what kind of history they have and understanding of evidence that a substance use disorder is there.
Q. So it sounds like a pretty comprehensive process for getting a patient fully assessed for participation in the MAT program; correct?
A. That is the goal.
Q. Is there a reason that you couldn't adopt a very similar process to reassess the patients who've been injured by the MWAP policy who are still not getting treated?

MR. NOLAN: Objection. Calls for speculation.

THE COURT: Are you able to answer that question, ma'am?

A. I would need you to clarify what you mean by those who were injured by the MWAP policy.

Q. Earlier you testified that there were patients who lost their medications that might have been optimal, I think was the word you used, under the MWAP policy; correct?

A. Correct.

Q. What efforts have you taken to identify those patients?

A. I have not worked to identify the patients that, several years ago, had a denial through the MWAP request program.

Q. Could you identify those patients if you wanted to?

A. I believe that we can pull that data out of central pharmacy.

Q. And can you just explain for the record why you haven't done that, to identify the patients whose medications were discontinued under MWAP?

A. Because the patients continued to have access to our care and are continuing to be evaluated and treated by providers. If there was a medication that was denied several years ago by the same provider -- when they were seen by the same provider or different provider, that doesn't necessarily mean that that specific medication is appropriate right now. The fact that they didn't get a medication at some point in the past doesn't

mean that there's something that is automatically being left out of their evaluation treatment process by their providers now.

Q. So sitting here today under oath, do you think that there are any patients whose medications were discontinued under MWAP who are not getting effective treatment for their chronic pain today?

MR. NOLAN: Objection. She's asking what she thinks without any basis.

THE COURT: Do you think that there are any patients.

MR. NOLAN: She's just asking for her belief, your Honor, without any questions about facts.

THE COURT: Why don't you rephrase the question.

MS. AGNEW: Sure.

Q. Let's talk about a period of time, Dr. Moores, when you were operating the reassessments for this litigation. Do you recall that?

A. Yes.

Q. And do you recall your participation in that process?

A. Yes.

Q. Can you explain to the Court how you participated in having patients reassessed?

A. Dr. Morley asked for my assistance with this. He told me that he was, as part of the litigation process, needed to arrange for patients to have a reassessment based on a list of

patients and that there was discussion about what that would be. I had come up with a form to make sure we at least had some minimal pieces of information that would come back. He asked me to contact all the facilities and the primary providers for those patients, ask them to do the reassessment. When the forms came back, I forwarded them to Dr. Morley and counsel's office. And if somebody was late on the form, I would contact them and have them come back. I also let them know that if they wanted -- because the MWAP policy was still in place, if they wanted to prescribe an MWAP medication at that time, that the review and approval would come from me rather than the assigned RMD so that they didn't have to worry that there was going to be a denial.

Q. And that form that you created for the providers, was that called the chronic pain assessment form?

A. I do not know.

Q. Can we agree it was about a two-page form with question prompts for the providers?

A. Yes.

Q. And isn't it true those question prompts asked, for instance, was there an effective medication that was discontinued?

A. I would have to look at it to be sure.

MR. NOLAN: Objection. If she wants to produce the form. I don't want my client to speculate on what the form

might say.

MS. AGNEW: She drafted the form, your Honor. She can tell me if she doesn't remember.

MR. NOLAN: That's not the best evidence.

THE COURT: I think the answer was recorded as I would have to look at it to be sure.

Q. Could you pick up, and it's right on your left, and I apologize, Dr. Moores, there's going to be a document in the lower right-hand corner that says P44. I've tried to put these in order so when we're finished, you can set them aside. Does that make sense to you?

A. Say that again, please.

Q. I tried to put them in order so when we're finished with it, you can set them aside. Does that make sense?

A. Thank you.

Q. Looking at P44, do you recognize this document?

MS. AGNEW: Let the record reflect, this is a three-page email that bears Bates numbers OAGMWAP-54250 to 54253.

A. I recognize that as an email, and I assume that that was the attachment that was with it.

Q. The original email at the bottom is from you; correct?

A. Correct.

Q. Do you have any reason to believe, sitting here today, that you did not send that email?

A. No, I believe that it's my email.
Q. Do you think that the attachment, which is a list of patients, is an accurate depiction of the list that you attached?
A. I really can't say, but I don't see why it wouldn't be.
Q. Since you've become the chief medical officer, have you ensured that each of the patients on this list is now being effectively treated for the chronic pain?
A. No.
Q. When you did these reassessments, and you just described the process for the Court and I appreciate that, you described collecting the reassessment forms back from the providers; correct?
A. Correct.
Q. Did any of those providers, in fact, find that the patient should be re-prescribed an MWAP medication?
MR. NOLAN: Objection. She's asking her to speak to what somebody else did.
MS. AGNEW: I'm asking --
MR. NOLAN: You need to rephrase the question.
THE COURT: I'm sorry, sir.
MR. NOLAN: She asked what other providers found, not what Dr. Moores found. You can have the question read back.
THE COURT: I thought the witness testified that the reassessment forms were returned to her?

MR. NOLAN: Correct. And she asked what other patients found --

MS. AGNEW: No, I asked what she saw on the forms.

THE COURT: Is there a reason she can't answer that question?

MR. NOLAN: Again, if she's asking what she saw on the forms about providing the forms, how can she remember? Again, we're asking questions about documents, your Honor.

THE COURT: The question was did any of those providers, in fact, find that the patient should be re-prescribed an MWAP medication.

Are you able to answer that, ma'am?

A. I don't know if it would apply as re-prescribed, but there were some forms that came back where, under the question, would you recommend an MWAP medication now that they said yes, put something down.

Q. As part of that reassessment process, you also testified that you told providers they could send the MWAP request form to you; correct?

A. Correct.

Q. And did you approve any MWAPs after this reassessment took place?

A. I can't be 100 percent sure. I think I did.

Q. Let's now turn to P45.

MS. AGNEW: For the record, this bears the Bates

number OAGMWAP 54790 to 54792.

Q. I'll give you a moment to look at that. You good?

A. Yes.

Q. So looking at P45, do you recall getting this email from Dr. John Morley?

A. I don't recall this email.

Q. Do you have any reason to believe, sitting here today, that this, in fact, didn't land in your inbox from Dr. Morley?

A. I probably got it.

Q. Isn't it true, attached to the email from Dr. Morley, is a list of patients who at least my office suggests were injured by losing MWAP medications?

A. Can you repeat that question.

Q. I can try. Isn't it true that attached to this email are a list of patients who at least my office believes were injured when they lost their MWAP medications?

A. I don't really know the origin of this list.

Q. But Dr. Morley's email says these are some of the MWAP inmates currently suing us, plus two more; correct?

A. That's what the line says there.

Q. And wasn't this the list, in fact, you worked off when you were doing those reassessments?

A. Most of these names -- most of them look familiar to me. So that's -- that's likely.

Q. So since you've become the chief medical officer, have you

taken that list and ensured that every patient on it is receiving effective chronic pain medication?

A. No.

Q. I think you testified earlier that MWAP did not allow the providers to give optimal care, and I'm paraphrasing, so forgive me, but is that the gist of your testimony?

A. The MWAP policy prevented providers sometimes to use their first-choice medication for a patient.

Q. And I think you said there were situations in which they had to go to alternative therapies; correct?

A. Correct.

Q. And you also said, potentially, the patients suffered; correct?

A. That is potentially what happened.

Q. Have you made any efforts to identify those patients who potentially suffered?

A. No.

Q. And I think when you testified about the new policy, 1.24A, I think that was defendant's 2, you didn't have a role in actually scribing the policy, but you accepted the info and the content from Dr. Morley; correct?

A. Correct.

Q. Did you then discuss the formulation of 1.24A with Dr. Morley, beyond him just handing you the content?

A. I asked him about the origin of what the intent would be

for the various details. From what I recall, he said it was pretty much based on the conversations that were occurring due to the case.

Q. And so, sitting here today, would you say that the creation of 1.24A was driven by this litigation?

A. That was my understanding at the time.

Q. What about the rescission of the MWAP policy itself, was that driven by this litigation?

A. That is also my understanding.

Q. And what about the reassessments that you were in charge of, was that driven by this litigation?

A. That was my understanding, also.

Q. When 1.24A came out, did providers have a problem understanding what you wanted them to do under the new policy?

A. Can you clarify whether you're talking about based on what I saw them do or what they were asking?

MS. AGNEW: I'm going to strike that, and I do apologize.

Q. I want to go back to the reassessments quickly before I move on. When you did the reassessments, did you notice any reassessments that were what you might consider exemplary?

A. Yes, there were some that were done very, very well.

Q. I want you to look at D52, and I know you have to shuffle around and I'm sorry.

MS. AGNEW: For the record, your Honor, I am not going

to use P46.

THE COURT: Is it P52?

MS. AGNEW: P52 is what I want her to look at. I'm not going to use P46 because my office inadvertently failed to redact HIPAA information, so we're going to set that aside.

Q. Dr. Moores, you can let me know when you're ready so I don't stare at you oddly.

A. I'm ready.

Q. Do you recognize the document I've marked as P52?

A. Yes.

Q. And can you tell us what it is?

A. It is an email that I received from Great Meadow, and it had been cc'd at the top, that it goes to Dr. Morley. And it included reassessment forms done by Dr. Karandy for two patients.

Q. So I don't know why, but the state defendants' emails cut off the "from" line on many of these. My belief is this is from you, the top email. Do you have any reason, sitting here today, to believe that was not from you to Dr. Morley?

A. I'm pretty sure it was because I remember wanting to show him Dr. Karandy's work.

Q. Isn't it true you wrote to Dr. Morley, perfect examples of reassessments by Dave Karandy; correct?

A. That probably is my statement.

Q. Did you then discuss with Dr. Morley having the other

providers go back and do their reassessments so that they were as comprehensive as Dr. Karandy's?

A. I did not.

Q. Do you know if anyone made any efforts to have the reassessments done with the comprehension and care that was done by David Karandy?

A. Say that again.

Q. Did anyone else make an effort to have the reassessments redone with the comprehension and care that was taken by David Karandy?

A. No.

Q. But you did discuss with Dr. Morley that these were perfect examples; correct?

A. Yes.

Q. Can you just tell us, sitting here today, why did you think these examples were perfect?

A. There were several things that I noticed with this. One is that it includes significant detail that is appropriate for figuring out diagnosis and options, and that there was evidence that figuring out what would be best for the patient was utmost in this provider's mind.

Q. Do you recall in that reassessment process, that you sent some of these patients to see Dr. Charles Argoff?

A. Yes.

Q. Can you please tell the Court who Dr. Charles Argoff is?

A. He's a pain specialist out of Albany Medical Center.
Q. Do you have any knowledge, sitting here today, what Dr. Argoff's specialty is in?
A. His primary specialty, I'm not sure. I just know he does pain specialty care, also.
Q. Is he highly regarded by DOCCS, in your experience?
A. Yes.
Q. And do you have any recollection of why you sent these particular patients to Dr. Argoff as opposed to whomever might have been the normal pain specialist in the hub?
A. There were several people that we send to pain specialists, and Dr. Argoff was added on because we didn't have enough pain specialists and the waiting for the regular pain specialist was too long for appointments. Dr. Morley knew Dr. Argoff and arranged to -- coordinated a new clinic that would be out of the Coxsackie -- our new hub clinics in order to get more access to pain specialists.
Q. Do you recall inputting the specialty referrals for Dr. Argoff?
A. I put in special referrals for several.
Q. My question was, do you recall putting in the specialty referrals for Dr. Argoff?
A. When I put specialty referrals in, I don't put who the provider is going to be.
Q. Very good. I didn't understand the distinction.

As part of the reassessment process that you were in charge of, did you ever ensure that the recommendations made by Dr. Argoff were followed by the providers on the ground?

A. I know that I got some reports, I didn't follow all of them.

Q. Do you know, sitting here today, why you didn't follow all of them?

A. Because I was not instructed to do so by my supervisor.

Q. Do you know whether or not anyone else from central office or DOCCS medical actually followed up to see whether these patients, who went out to see pain management, had those recommendations adopted by the providers in the facilities?

A. Not that I know of.

Q. Would that be important to see whether or not these patients actually got what the pain specialist recommended?

A. My experience is that most of the providers do implement what pain specialists recommend.

Q. I want to go back over your testimony about medical problem lists, and to do so, I'm going to ask you to find P4, which is a bound subset of the records of Mali Wilkerson.

MS. AGNEW: Your Honor, what we're going to do is if we talk about specific pages, we're going to make an explicit exhibit, but we wanted to have everything available here for all the parties, if that makes sense.

THE COURT: Yes, ma'am.

Q. So once you have Mr. Wilkerson's documents, I'm going to direct your attention to the page marked 160. It says Mali Wilkerson, 160. That's the big numbers in the bottom there.
A. I found it.
Q. And forgive me, Dr. Moores, I really want the Court to understand the medical problem list. So, can you tell me, looking at Mali Wilkerson 160 and 161, generally speaking, what is that document?
A. This is the problems that is in our mainframe FHS1 for this patient, Mali Wilkerson.
Q. Do most, if not all of the patients being treated by DOCCS have a medical problem list?
A. Yes.
Q. And I think you provided some testimony earlier, I just want to fill in the gaps for everyone.

At some point in time, did you work for Elmira's reception area?
A. Yes.
Q. Did you, in fact, code medical problems for patients who came in through reception?
A. I was involved with the coding process.
Q. Can you explain the coding process to the Court.
A. So there are certain things that need to be coded immediately with reception and key areas such as their status for certain infectious disease situations because we're

required to do that before they can be placed into a facility. Also, any significant medical problems get coded there, and vaccines, and certain testing gets coded on a regular basis.

Q. If you look at Mr. Wilkerson's, he's got a code, for instance, there V801, wheelchair required, independent ADL; correct?

A. Correct.

Q. And would you code things like that in order for movement and placement, to know the best facilities for a patient?

A. Correct. There are certain items that have been added into the problems coding systems so that when class and movement is considering a move for an individual, they take those into consideration, and wheelchair is one of them.

Q. So when you were working in Elmira reception, the accuracy of the codes, would you describe it as important to movement and classification in getting a patient to where he needs to be housed?

A. Yes.

Q. And I'm also going to note that you also at the top of the medical problem list, you put a medical classification number; correct?

A. There is a medical classification number towards the top.

Q. Right. And can you tell us, just based on this document, what Mr. Wilkerson's was when he came into DOCCS' custody?

A. 1.

Q. What does that mean?
A. Let me just clarify. It's a medical level 1 that can be changed over time. So I can't be sure if it was changed at any point for this patient.
Q. Okay. But the medical level of 1, what does that mean?
A. There are three medical levels. 1 is the highest, meaning they require the highest level of access to nursing care primarily. So if somebody has a situation, we want to make sure there is 24-hour nursing available, then they would be a level 1.
Q. Do the medical levels also try to indicate where a patient should be housed?
A. They do, because we have facilities where the higher levels, like a level 1, has to be in a facility that has 24-hour nursing.
Q. When you were a provider at Elmira, generally speaking, where was the medical problem list kept in a patient's chart?
A. They would print it out periodically and keep it in front of their chart.
Q. Do you have any notion of why it was kept in the front of the chart?
A. For easy reference.
Q. So could we agree that a medical problem list is a reference tool for the providers to dictate the care for a patient in DOCCS' custody?

A. I don't know if it would dictate the care, but it's important to know what's on the problem list in order to take care of the patient.

Q. So I think your counsel was eliciting some testimony from you about the code 338; correct?

A. Correct.

Q. And how does code 338 fold into this case, so the Court's clear?

A. 338 by itself was introduced with the new policy 1.24A. With it being on the problem list, it makes it easy for us to run reports to make sure that the frequency of appointments for the pain management occur.

Q. And 338, if I'm a provider, it's also going to tell me in the front of the chart that this patient has to be followed for chronic pain management; correct?

A. Correct.

Q. So it's an indicator to the provider of the medical needs of the patient; correct?

A. It's not a typical term that we would use for somebody following. Generally, we choose the diagnoses that need to be followed that might result with the chronic pain.

Q. So you described doing an audit; correct?

I apologize. You didn't do the audit. You oversaw a 338 audit; correct?

A. We have 338 audits that have started and continue.

Q. And you did an audit, though, as you described in your declaration of 38 patients, didn't you?
A. I did look for 338 on that list of patients.
Q. As a preliminary matter, where did the names of the 38 patients you audited come from?
A. From my counsel.
Q. Isn't it true you had the medical records of those 38 patients printed out and sent to you as PDFs from their facilities; correct?
A. They were scanned to me, yes.
Q. And included in the patients' medical records, hopefully, since February of 2021, would be a copy of their medical problem list; correct?
A. Correct.
Q. And were you then looking at those to see whether or not 338 had been added?
A. Yes.
Q. And had 338 been added to all of those 38 patients?
A. No.
Q. And then what steps did you take to add 338, which I believe is what you've testified to, to those 38 patients?
A. So either I attempted to put the code in or I had one of the nursing personnel in central office attempt to put the code in.
Q. And why was it important to put the code in on those 38

patients?
A. To be in compliance with our policy.
Q. Which policy is that?
A. 1.24A.
Q. Did you have an awareness, when you were going over that list of 38 patients, that there were more than 38 patients implicated in this lawsuit?
A. I only have the names that I had gotten from counsel.
Q. But you've got a list from me, which I think we talked about a little bit ago, actually, Dr. Morley sent it to you, this has way more than 38 patients on it; right?
A. The list that I had when they asked to do -- to have me contact for doing those reassessments in the fall of 2020 was a longer list.
Q. Did you take this list from the fall of 2020 and check it to make sure that each patient had 338 indicated?
A. No, I've not done that.
THE COURT: The list you're referring to is exhibit?
MS. AGNEW: P45, your Honor. I apologize.
THE COURT: Thank you.
Q. So what steps did you take to ensure that each patient injured by the MWAP policy has 338 added to their medical problem list?
MR. NOLAN: Objection. There's no foundation for the injury of the MWAP policy.

MS. AGNEW: Well, I asked her if she took any steps to identify the patients, right, and she said no. She didn't say there are no patients. I think we all know there are patients.

MR. NOLAN: Objection. She has not established that there are patients injured by the MWAP policy. She testified that there were potentially people who had potentially adverse effects, but there's been no testimony from anybody that there was ever any individual patient who was a victim or injured by the MWAP policy.

MS. AGNEW: Your Honor, papers are already a part of the record. They're certainly listed in our papers submitted to this Court for a motion for injunction delineating almost by name the patients injured by the MWAP policy.

THE COURT: The only question is whether the witness can answer the question.

MR. NOLAN: Is there a ruling on the objection, your Honor?

THE COURT: The witness's word was potential. Are you able to answer the question as it's phrased or do you need it rephrased, ma'am?

THE WITNESS: I don't understand what the definition of "injured" means for this.

BY MS. AGNEW:

Q. You're aware, Dr. Moores, that there were MWAP request forms; correct?

A. In the past when the policy was in place, there were MWAP request forms.
Q. Does DOCCS still possess those MWAP request forms?
A. I don't know if they have the forms. I know that the key information from them was kept by central office as far as the number of -- as far as the patients, what they were asking for, whether it was approved or denied.
Q. Have you asked for a copy of that key information that identifies patients whose medications were discontinued under MWAP?
A. I've not asked for the list of those that had medications denied.
Q. Did you ask for any list?
A. Not involving MWAP.
Q. So did you ever take any action with those people whose information has been retained by central office whose MWAP requests were denied to cross-reference and make sure that those patients had 338 in their medical problem list?
A. No.
Q. You testified earlier about a non-formulary audit; correct?
A. Are you referring to the non-formulary review I did for regional medical directors?
Q. I am. Can you tell me when you conducted that non-formulary audit?
A. I did one audit around August of last year.

Q. I'm going to direct your attention to the document, it says P53.

MS. AGNEW: For the record, this bears Bates number Moores 7355 to 7362.

Your Honor, I'd like the record to reflect this was produced to us with HIPAA protected information, we did redact it.

THE COURT: Yes, ma'am.

Q. Did you find --

A. I did.

Q. Do you recognize the document that I've marked P53?

A. I do.

Q. What do you recognize that to be?

A. These are my personal recordings of the non-formulary denials done by the RMDs in August. Then, after that is the -- of my audit of denied referrals by the RMDs.

Q. So is it fair to say the first one, two, three, four, five pages are your typed notes, and then the last three pages are handwritten notes where you actually went over the non-formulary requests?

A. Yes.

Q. And so, can you tell me, what were your findings after you did that RMD non-formulary audit in August of 2022?

A. In general, I had concerns about the RMD's assessment of what to deny.

Q. Isn't it true for defendant Mueller, you wrote, asking for multiple evaluations before the med is to be given. That is an inappropriate process within the NF request procedure — I'm going to skip a little — these were specialist recommended. SM does not have the credentials to review the work of a rheumatologist.

Does "SM" refer to Susan Mueller?

A. Yes.

Q. And let's move down to Paula Bozer. Does PB refer to Paula Bozer?

A. Yes.

Q. And you say all inappropriate denials; correct?

A. The 3 out of the 20 that were denied are inappropriate.

Q. And you wrote, PB's comments implied she knew more about the foot problems of a specific patient than the podiatrist and PCP did; correct?

A. Correct.

Q. So what was your overall impression of the RMD's performance when doing non-formulary audits?

A. It was inadequate.

Q. And yet, in October of 2022, you finally removed the RMDs from that process; correct?

A. Correct.

Q. In fact, it was October 31st of 2022; correct?

A. Correct.

Q. In fact, October 31st of 2022 was less than two weeks before you signed your declaration for this Court; correct?
A. I don't recall.
Q. Do you want to go back to your declaration and look at the date you signed it? It's P32, and your signature is on page 26.
A. So that was November 14th.
Q. So why did you wait from August of 2022 when you knew the RMDs were conducting inappropriate denials, until October 31st of '22 to take them off?
A. I -- there were a couple of things. One is that I had to -- I got sent to peace officer school. I also got sent to required training with the ACA, American Correctional Association. I also had to set up and make sure we were ready to go with others to do the review process.
Q. And I just want to frame this. In August of 2022, you found that their denied referrals were generally speaking inappropriate; correct?
A. That -- not the majority, just 3 out of 20 for each, each of those.
Q. But 3 out of 20 were denied, right, 17 were approved?
A. Correct.
Q. So all of their denials were inappropriate?
A. Correct.
Q. So at what point did you go back and review all the denied

non-formularies from August to October 31st when you took them out?

A. I haven't done all of them.

Q. Have you done any of them?

A. I -- no, actually, I have not. I have not.

Q. Wouldn't it be important, since you know that the RMDs were making inappropriate denials, to go back over all of those medications that were denied to see if there were patients who were waiting for stuff they need?

A. That is reasonable. It would be appropriate.

Q. And I think you testified that you also did an audit of specialty referrals; correct?

A. The denied referrals that the RMDs had denied.

Q. I'd like to direct your attention to the document I marked as P54.

MS. AGNEW: For the record, that bares Bates numbers Moores 7363 through 7398.

Q. Are you ready?

A. I am ready.

Q. Do you recognize this document?

A. Yes.

Q. What do you recognize it to be?

A. This is more of the notes that I had with doing the non-formulary audits -- not the non-formulary. The denied referrals audits on the RMDs.

Q. I just want to make the record really clear, what are we talking about when we talk about these referrals? And I want to contextualize it. Specialty referrals; correct?

A. Yes.

Q. And what does that mean?

A. Our specialty referrals are reviewed by a vendor, Kepro, very similarly to what health insurance companies do to decide whether they're going to approve a specialty visit for what is being requested. And so, Kepro uses primarily InterQual criteria so that it's equivalent for the most part to Medicaid approvals. They have some other things where they have special instructions to do otherwise for us. If they find that based on what the provider wrote in the referral, it doesn't meet the InterQual criteria, they don't do a denial because we haven't given them the right to deny the referrals, but it's listed as a preliminary denial. Then it is to be reviewed by -- at least previously, it was only the RMDs that reviewed them who would then look and decide whether it needed to be approved or have a final denial, and they would enter their impressions and make the choice.

Q. Just to be very clear, it only gets kicked from Kepro when they give that preliminary denial; correct?

A. Correct.

Q. So if Kepro says everything aligns with Medicare or Medicaid, I apologize, the patient goes to the specialist;

right?
A. Right.
Q. When it gets kicked, under the old regime, it went to an RMD; correct?
A. Correct.
Q. Among those specialty referrals might also be referrals out to pain management; correct?
A. Correct.
Q. And so, you did an audit here, and can you describe for the Court what you did?
A. I had somebody pull a certain number of denied referrals for each of the RMDs so I can review what was written and what -- what the referral request was for and what the RMD review details were entered as to why they denied it.
Q. And what did you find after you conducted this audit?
A. I don't recall all the details, but I -- there's -- because I don't have my summary here. There's definitely some that were concerning and to help to make me realize, at least for pain specialty -- the InterQual criteria are very complex, so it makes it very difficult for the providers to write the correct things to have it approved. So I had called Kepro and asked them to just do automatic approvals on that and we would follow over time to see if that would cause a problem.
Q. When I flip through this, there is handwriting after each referral. Is that your handwriting.

A. It is.
Q. And there are several, at least, that say inappropriate denial; correct?
A. Yes.
Q. And so, when did you do this, this particular audit?
A. This, I believe, was also in August.
Q. Was there a time when you finally took the RMDs off of these reviews, at least for pain specialists?
A. For the pain specialists, yes, that month I did call Kepro and told them that they're just to do automatic approvals on all pain specialty requests. So that would be with a pain specialist or a physiatrist.
Q. When you did this audit, you also found instances where denials for other specialty providers implicated chronic pain; correct?
A. Yes, that can happen.
Q. In fact, in your audit, you saw it; right?
A. I don't recall this audit specifically.
Q. Let's go to Moores 7397. I'm sorry. It's in the lower right-hand corner. I think you said earlier you made a comment that your summary was in here; is that correct?
A. Well, it was in the other document.
Q. I'm sorry. I did my best.
A. But these have the details written on them.
Q. You want to refresh your recollection and read over this

real quick and tell the Court what your summation was.
A. My review of this referral, and then also reevaluating the details of what the diagnosis and concern is for the patient and looking it up and up to date to see if it was recommending anything else led me to believe that the appropriate thing was to allow this orthopedic referral to occur.
Q. And would an orthopedic referral implicate potentially chronic pain in a patient?
A. It could.
Q. So what steps have you taken since you conducted this audit to keep the RMDs from making inappropriate decisions?
A. It takes a bit to do the due process with the RMDs, especially, unfortunately, with the other scheduling conflicts that I had. However, I have done it with one RMD so far and have totally removed them from RMD work, and I will be doing counseling sessions with the others.
Q. Have you done those counseling sessions as of today?
A. No.
Q. Can you tell us for the record, who's the RMD you removed?
A. Dr. Bozer.
MS. AGNEW: Your Honor, could I take five minutes?
THE COURT: Yes, ma'am.
(Recess)
BY MS. AGNEW:
Q. Are you ready, Dr. Moores?

A. I'm ready.
Q. Thank you. I want to talk about now the SURN audits.
Isn't it true the SURN audits for chronic pain started November of 2022?
A. I'm not absolutely sure, but that sounds correct.
Q. Do you know, did you direct those audits to start taking place before or after you submitted your declaration to this Court?
A. I don't recall it being associated with the declaration.
Q. Do you think that any of the steps that you took were prompted by the fact that we were going to have this hearing?
A. I actually didn't know about the hearing for a while. I did know, having taken over for -- officially for chief medical officer in the middle of the summer and that this -- and I had found out about the injunction and that we'd be moving in a direction -- that was one of the things I knew needed to be done, was to look at the new policy that had been out, meaning newer than the MWAP, and whether or not we're compliant in what we need to do to become compliant.
Q. Did you have a list somewhere of things you knew needed to be done?
A. Yes, actually.
Q. Did you provide that list to your attorneys to give to us?
A. I don't recall.
Q. I'm going to turn your attention to the document I marked

as P55.

MS. AGNEW: For the record, that bears Bates numbers OAGMWAP 103561 through 103564.

Your Honor, we have redacted this to comply with HIPAA.

THE COURT: Yes, ma'am.

MS. AGNEW: The patient names that are unredacted are ours for whom we have releases.

Q. Dr. Moores, do you recognize this document?

A. This is the document that the SURN unit initially created to start the process for auditing compliance with 1.24A.

Q. Did you have a hand in developing this document?

A. They developed it based on the policy, but did bring it to my attention when they had completed it.

Q. Did you review it before it was kind of put in to circulation, so to speak?

A. I at least reviewed it around the time they started.

Q. Can we agree that this is an assessment tool used by a senior utility review nurse to conduct an audit of patient records for compliance with policy 1.24A?

A. Yes.

Q. And have the SURNs who are completing these audits been sending these to your office?

A. When they complete a facility audit, which includes this, the reports eventually get to me.

Q. And we requested these from you. Did you hand those over to your counsel to produce to us?
A. I don't know how they got there.
Q. Yes or no, did you give them to your counsel?
A. I don't recall if I did or not, if I had given her copies.
Q. About how many of these chronic pain management assessment tools have you collected since the audit started?
A. It's not many because they've just gotten started, and they do it with a comprehensive facility audit.
Q. I want to look at P55 itself. There's these lists and they say indicator number above the start of the list. Do you see that?
A. Yes.
Q. And it looks to me, and correct me if I'm wrong, that these are certain elements of 1.24A that the SURN wants to see reflected in the records he or she is reviewing; correct?
A. Correct.
Q. And so if you look at number 5, it says specialty consults in the chart. What does that mean?
A. I would assume that it's a specialty consult report that they could identify whether it's been filed in the chart.
Q. And is that because the SURN wants to make sure that specialty consult is getting, from wherever it comes in, actually placement of the patient's chart so the provider can see it; correct?

A. It's not so that the provider can see it. It's so that after the provider reviews, it needs to be filed in the chart.
Q. To your knowledge, do most providers initial that specialty consult once they've reviewed it?
A. Most of them do.
Q. And then under policy 1.24A, isn't it true that the provider, if they're not going to follow the recommendation of the specialist, they need to be noting that in the patient's AHR; correct?
A. Correct.
Q. And there are, in fact, systemic compliance issues with that element of 1.24A; correct?
A. Commenting on systemic, I'm not sure to what degree.
Q. Are there compliance issues?
A. We definitely are not 100 percent compliant.
Q. You reviewed, in fact, 38 patient charts; correct?
A. Correct.
Q. Isn't it true, there were compliance issues with that element of 1.24A in those 38 charts?
A. There were.
Q. So what I need to understand is how does checking to see if the specialty consult is in the chart, also audit whether or not the provider has recorded why he or she is not following a recommendation, because I don't see that here.
A. That's correct, it's not here.

Q. Why isn't it here?
A. Because this audit form needs to be revised. It's a missing element.
Q. So as this audit form was developed and disseminated and used to date, it is not going to catch when a provider does not follow the recommendation of a specialty provider and make the proper notations in accordance with 1.24A; correct?
A. We would assume it may not if the SURN is only looking to see whether the consult is in the chart.
Q. To your knowledge, was there SURN training conducted on how to review for compliance with 1.24A?
A. The supervisor of the SURN unit had done training with them about what was expected in the audit, but I don't know the details of the training.
Q. I want to talk last about these medication discontinuations at transfer. Have you done any training of providers to ensure that they sit down with a patient after the patient is transferred before they discontinue their medications?
A. No.
MS. AGNEW: I have no further questions, your Honor.
THE COURT: Thank you.
Redirect, counsel.
MS. KILEY: Your Honor, may I have five minutes, please.
THE COURT: Yes, ma'am.

MS. KILEY: Thank you.

(Recess)

THE COURT: Did you want to admit some documents?

MS. AGNEW: Yes, your Honor. Your Honor, if I may, due to my own clerical errors that are never ending, I'd like to move into evidence the documents that we just used during Dr. Moores' cross. That would be P32, P44, P45, P52, P4, but only pages Mali Wilkerson 160 to 161, P53, P54, and P55.

THE COURT: Any objection?

MR. NOLAN: No objection.

THE COURT: Received.

(Plaintiff's Exhibits P32, P44, P45, P52, P4, P53, P54, P55 received in evidence)

THE COURT: Yes, ma'am, Ms. Kiley.

MS. KILEY: Thank you, your Honor.

REDIRECT EXAMINATION

BY MS. KILEY:

Q. Dr. Moores, you testified quite a bit on your cross about the annual individualized assessments. What, if anything, does the presence of an individualized assessment have to do with the MWAP policy?

A. Nothing.

Q. Under 1.24A, if a patient previously discontinued -- excuse me. If a patient previously had a medication discontinued under MWAP, under 1.24A, can their provider now prescribe that

medication?
A. It's not related. 1.24A has no limitations on prescribing.
Q. And to go along with that, does anything in 1.24A dictate choice of care?
A. No.
Q. You talked earlier about the presence of the 338 code and how it's --
MS. KILEY: Withdrawn.
Q. The presence of a 338 code, can a patient coded 338 receive a medication that was previously discontinued under MWAP?
A. Yes.
Q. Is there any policy in place that would preclude that?
A. No.
Q. Does the existence of a 338 code on a medical problems list have anything to do with the MWAP policy?
A. No.
Q. I want to go back to your testimony regarding the review of the non-formulary requests.
During the course of your review, when a non-formulary request is denied, does that mean a patient is being denied adequate care?
A. No.
Q. Why is that?
A. If the non-formulary request is denied, at least as things are now, we reach out to that provider to talk about options.

Generally, the only time it's denied is if it sounds like it might not be the optimal care for that patient.

Q. I'd like to talk about Plaintiff's Exhibit 45, if you wouldn't mind just pulling that up for a second.

A. Okay. I have it.

Q. Dr. Moores, what is the date on plaintiff's 45?

A. September 28th, 2020.

Q. Can you please repeat for the Court what it says on that first line.

A. These are some of the MWAP inmates currently suing us, plus two more.

Q. Receiving this email with this attachment, do you know anything about these patients, other than the fact that they were suing DOCCS?

A. No.

Q. Just because an inmate might start a litigation, does that mean that they're not getting adequate care?

A. No.

Q. Why is that?

A. Because until you investigate, you can't tell if there's -- what the issues are and if there's anything that's a problem.

Q. And so was there anything to suggest at the time that they weren't getting treated for their pain?

A. Nothing that I knew of.

Q. Could the patients on this list in this email in this

attachment, can they currently receive a medication that was previously denied under MWAP?

A. Yes.

Q. What would be the circumstances?

A. If they're being evaluated by a current primary care provider and the primary care provider believes that what was previously on the MWAP list is an appropriate medication right now, they can prescribe it.

Q. Is there anything in place to prohibit their primary care provider from getting the pain treatment that they need?

A. They can prescribe anything.

Q. Dr. Moores, have you heard anything today from Ms. Agnew to suggest any patient is being denied adequate care today?

A. No.

MS. KILEY: I have no further questions.

THE COURT: Thank you. Recross.

MS. AGNEW: Your Honor, we're done. Thank you very much.

THE COURT: You may step down.

(Witness excused)

Who's next?

MS. KILEY: Your Honor, we would like to call Dr. Khan, he's not available until tomorrow morning.

THE COURT: All right. Anything else we can do today? You want to talk about your documents?

MS. KILEY: Sure.

THE COURT: Have you folks had a chance to confer about this some more to find out if it's really going to be a problem?

MS. AGNEW: We have not, your Honor.

THE COURT: Is that worth doing or do you want to just dive into it?

MS. AGNEW: Let's just dive into it. If they want to stipulate they'll only use them for rebuttal, that's fine, we'll withdraw our motion.

THE COURT: Ms. Kiley.

MS. KILEY: We'll stipulate to that.

THE COURT: That solves that.

Anything else today?

MS. AGNEW: Not from plaintiffs, your Honor.

THE COURT: Off the record.

(Discussion off the record)

THE COURT: Mr. Dockery, would you raise your right hand and give your attention to Ms. Phillips, please.

AARON DOCKERY,

called as a witness by the Plaintiffs,

having been duly sworn, testified as follows:

THE DEPUTY CLERK: State your name and spell it for the court reporter, please.

THE WITNESS: Aaron Dockery, A-a-r-o-n D-o-c-k-e-r-y.

DIRECT EXAMINATION

BY MR. MORRISON:

Q. Good afternoon, Mr. Dockery. How are you?

A. Good afternoon. I'm all right.

Q. How old are you?

A. 37.

Q. Do you have any children?

A. Yes.

Q. How many children do you have?

A. Two.

Q. What are their ages?

A. 12 and 7.

Q. I know you're currently at the MDC, but where do you currently reside?

A. Marcy Correctional Facility.

Q. Is that a facility for the New York City Department of Corrections?

A. Yes, it is.

Q. You're currently in custody; correct?

A. Yes.

Q. How long have you been in custody?

A. A little over eight years.

Q. During your time in custody, did there come a point where you received a diagnosis for an illness?

A. Yes.

Q. And about when was that?
A. I was diagnosed with multiple sclerosis in 2016.
Q. Can you just briefly tell the Court a little bit about what you're feeling or what led up to that diagnosis?
A. My initial symptoms were facial numbness, loss of fine motor skills, loss of balance, and tingling in my hands and my feet.
Q. And when you started experiencing these symptoms, what facility were you living in?
A. Five Points.
Q. Do you recall who your primary care provider was at Five Points at that time?
A. No.
Q. How long after you were receiving these symptoms did you ultimately get diagnosed?
A. About 45 days.
Q. After the diagnosis, can you describe what type of treatment you were provided?
A. Yes. When I was first diagnosed, I was given Neurontin to help with the tingling in my hands and my feet. I was given Ditropan to help with my bladder issues. I was given Elavil.

But these are initially; right?

Q. Yes, originally.

You mentioned you were given Neurontin for the tingling in your feet. Can you describe a little bit the

tingling in your feet, was it painful or was it --
A. Yes.
Q. So elaborate.
A. It's like your foot falls asleep. When your foot first falls asleep, you're not going to walk on it. It's like you got to tap it for it to come back alive, and then, eventually, you could start walking on it. That's what it's like, it just don't go away. So I could tap it, but the tingling and the needles are still there.
Q. How long would these episodes with the tingling in your feet and the pain go on?
A. Hours, sometimes days.
Q. Were there specific times of the day that would happen or was it random?
A. Random.
Q. You said you were prescribed Neurontin. How did that Neurontin medication treat those symptoms, if at all?
A. It didn't make it totally go away, it just takes the pins and needles sensation out of it. So I still feel like, you know, the sleepiness of my hands and my feet, I still could feel that, but it doesn't hurt where I can't walk or I can't deal with it.
Q. Would you describe that medication as effective?
A. Yes.
Q. Were you informing your medical providers at the time that

the medication was effective in helping you manage the tingling in your feet?

A. Yes.

Q. Was there a point in time while you were in DOCCS' custody after you were prescribed the Neurontin that that prescription was taken away?

A. Yes.

Q. How long after you first started the Neurontin was it taken away?

A. Not too long. I was diagnosed at 16, I started the Neurontin at 16, it was taken away in '16.

Q. Can you tell me what, if anything, you were informed about why that medication was taken away?

A. I was told that they're not giving it anymore.

Q. And who told you that?

A. The doctor.

Q. What did you say in response, if anything?

A. I asked why and then I asked if there was any alternatives, if anything else would work.

Q. Was any other alternative medication provided at that time?

A. Yes.

Q. Do you recall what type of medication that was?

A. It was a lot. I'm not too sure of everything in order. But it was, like I said, Elavil, before it was Depakote. It was a lot. It was probably five or six different medications

over a few months' span.

Q. Were all these medications you just mentioned provided at the same time or separately?

A. Some of them were and some of them weren't. Some of them were thought to be maybe be more effective together and some were given singly, like the Cymbalta.

Q. When you were prescribed these alternative medications after Neurontin was prescribed, did you take them willingly?

A. Yes.

Q. Why did you do that?

A. Because I needed help.

Q. Did you trust the doctors were trying to get you effective medication?

A. I was a little leery at first because I was wondering why I was changing from something that was working. And then, over time, like, I would get -- another one I took was Tegretol and it gave me real bad diarrhea. So, at some point, I started to question the whole process of, like, how many different medications am I going to go through.

Q. While they were trying these new medications on you, did you ever inform your provider that, hey, the Neurontin worked for me?

A. Yes.

Q. Did you ask them at that point, why can't I get the Neurontin back?

A. Yes.
Q. What type of response would you get, if anything?
A. At several different times, I wrote grievances to try to see what was the reasoning. Like I said, I wasn't given a reason why I wasn't getting it. So I did some research on it, I found out it's not a narcotic nor did it make me high or anything, but it helped with allowing me to move up to motivate to not have to be in a wheelchair, and also to deal with my illness, so it was important to me that I got it back.
Q. Did the alternative medications that you were provided, I think you said Elavil, Depakote, did they cause any side effects for you?
A. Yes.
Q. And did you inform your medical provider about those side effects?
A. Yes.
Q. And what, if anything, happened after you informed your medical provider about those side effects?
A. Well, most times, they would discontinue it and try to find me something else.
Q. How long did this go on for?
A. Can you be more specific.
Q. Fair enough. How long were you being prescribed alternative medications after the Neurontin was discontinued?
A. For years.

Q. At some point in time, did you get re-prescribed Neurontin?
A. Yes.
Q. And about what year or what time was that?
A. That's a hard question to answer because I was restarted and stopped several times over the course of a few years.
Q. Tell me a little bit about that, why did that occur, if you know?
A. All right. So I was having really bad episodes in the beginning because I was still learning my disease, what I could, what I couldn't do, so I was kind of pushing myself at times. So I was having really bad episodes where I was requiring hospitalization and ambulance trips. After going to the hospital so many times, they would write on their discharge papers that I needed the Neurontin in order to, you know, control my symptoms better.
Q. Can I stop you for a second.
A. Yes.
Q. When you were going to these hospitals, was this a point in time that you're on Neurontin or were you off Neurontin?
A. I was off.
Q. So you would go to the hospital, and your discharge papers, as you understand, would suggest you be provided Neurontin?
A. Yes.
Q. Would you tell the outside specialists or doctors, when you were in the hospital, that Neurontin was effective in treating

your pain?
A. Yes.
Q. I'm sorry. Continue about being taken on and off Neurontin.
A. There would come times where I would run into certain providers. I know Dr. Miller was one of them, and they would really fight for me.
Q. Was that at Five Points?
A. This was in Coxsackie. I know he was really trying to fight for me. So he would take certain paperwork and put a standby request in using that paperwork. And sometimes he would go over the regional medical director, whether it was Dinello or Mueller, and he would go right to Koenigsmann, which was the CMR at the time, and I would get it approved that way through certain other doctors.
Q. Would Dr. Miller show you the MWAP request forms?
A. Yes.
Q. Did he talk to you about the MWAP policy?
A. Yes.
Q. So when he would get this, the approval, according to your understanding that Dr. Miller would go over the RMD's head to the chief medical officer, how long would you remain on Neurontin?
A. For a while. Mostly, unless I changed another facility, which happened in this case. In this case, Koenigsmann had

approved me himself. And I thought I was all right for a while because the refills was 100 or something, it was something ridiculous, so I'm like I'll be alright for a while. Then I moved to Shawangunk, and when I moved to Shawangunk, everything changed back to normal.

Q. Can you tell me, roughly, about what time, what year you moved from Coxsackie to Shawangunk?

A. I believe it was 2018 or 2019.

Q. And when you got to Shawangunk, do you remember who your medical provider was?

A. It was Dr. Lee.

Q. And you said everything changed. What did you mean by that when you got to Shawangunk?

A. They started taking me off the Neurontin.

Q. Was that immediately upon your transfer to Shawangunk?

A. Yes.

Q. And how did you learn that you were being tapered off of Neurontin when you got to Shawangunk?

A. I was told by the nurse.

Q. Did Dr. Lee ever sit down and talk to you about that?

A. No.

Q. How long after you got to Shawangunk do you recall first seeing Dr. Lee?

A. It was a while, a few months, two or three months.

Q. When you saw Dr. Lee for the first time, had you already

been tapered off of Neurontin?
A. Yes.
Q. And by the way, what do you mean by tapered, just to be clear?
A. Tapered, it was a couple days they were giving me for a little bit, for maybe like two or three days, and then it would discontinue.
Q. During this period of time, were you informing nursing staff or medical staff that Neurontin was effective in treating your pain?
A. Yes.
Q. Did they provide you any alternative medications when they were weening you off or taking you off Neurontin at Shawangunk?
A. No.
Q. What pain medication, if at all, being on at Shawangunk?
A. They reverted back to a lot of the old stuff that I had already, the Elavil or the Cymbalta or the Tegretol, you know, a lot of the old medication that wasn't working before, they just re-prescribing them to me.
Q. At some point, did you get your Neurontin back, though?
A. Yes.
Q. And when was that?
A. I don't know because I think I had got it back -- I believe I got it back again and then they took it away again, then I believe I got it back one more time before they took it away.

But the final time I got it back I think was maybe two years ago, almost three.

Q. Did you ever learn that when you got your Neurontin back the final time, it was during the MWAP policy period or after the MWAP policy period concluded?

A. It was after.

Q. And what facility were you at at that time, if you recall?

A. Five Points.

Q. At some point, you transferred to Marcy Correctional Facility?

A. Yes.

Q. When you transferred to Marcy Correctional Facility, it's fair to say that you transferred on a prescription of Neurontin?

A. Yes.

MR. NOLAN: There's been a lot of leading and I understand why, but if we could do more of a traditional direct, I'd appreciate it.

THE COURT: Okay. Although I'm not sure that these facts are much in dispute. I mean, you have the medical records.

MR. NOLAN: Understood, your Honor. I just want to make sure that we're doing this correctly.

Q. After Five Points, what was the next facility you were housed?

A. Marcy Correctional.
Q. And when you arrived at Marcy Correctional Facility, did you have an active prescription of Neurontin?
A. Yes.
Q. Now I'm going to direct your attention to early December of 2022, just a few months ago. Okay?
A. Yes.
Q. Around that time, do you recall your Neurontin medication being discontinued?
A. Yes.
Q. Do you recall any other medication being discontinued?
A. Yes.
Q. And can you tell the Court what is your understanding of why that medication was discontinued?
A. Would you like the story or just a straight explanation?
Q. Start with a straight explanation.
A. The straight explanation is I refused to let a nurse flash a flashlight in my mouth before she wiped it down.
Q. Your understanding, why would a nurse being using a flashlight in your mouth?
A. They're allowed to if they feel that you're taking medication and they might not have maybe seen the medication in your mouth, so they do have a right to use a flashlight.
Q. Do you have any objection to a nurse using a flashlight to make sure you're taking your medication while at Marcy?

A. Not at all.
Q. What was your objection?
A. So my objection was the previous day, I allowed her to do it, but the second day, there was five other gentlemen, they were part of the MAT program. So, really, the flashlight, it was really reserved for those guys, and she puts it really close to their face. This was the time we just had a COVID outbreak, we had the flu going on, and we had some other respiratory illnesses that was going on. I'm watching her flash the other guys, and when she goes to put the flashlight in my face, I see specs on the lens. I asked her, can you please wipe the flashlight down before you stick the flashlight so close into my face. She told me she didn't need to.
Q. When you say she, who is she?
A. Nurse Reilly.
Q. And she's a nurse at Marcy?
A. Yes.
Q. So what happened after she said she wouldn't wipe down the flashlight before she checked into your mouth?
A. They discontinued my -- that was on the 1st, they discontinued my meds on the 2nd.
Q. Can you tell the Court how you learned your medication was discontinued?
A. When I went down to receive my meds the next day, I was told that they were discontinued.

Q. What medications were discontinued, just to be clear?
A. Neurontin and baclofen.
Q. What is baclofen, to your understanding?
A. Baclofen is a muscle -- an anti-muscle spasm medication.
Q. What's your understanding of why you're prescribed baclofen?
A. Because I have muscle spasms in my legs.
Q. So when you went to the nurse's window and learned that your medication was discontinued, what did you do?
A. I asked why, she said because I refused the mouth check. I explained to the nurse that I'm not refusing the mouth check, I just wanted to be sanitary and I felt it was unhealthy for you to have the flashlight so close to my face.
Q. Prior to you learning at the window, just to be clear, did any medical provider at Marcy sit down with you and discuss this incident?
A. No.
Q. Did any medical provider sit down with you and inform you why your medication was discontinued?
A. No.
Q. Did you get a chance to tell any medical provider why you refused to take your medication on, I think you said December 1st?
A. No.
MR. MORRISON: I have nothing further. Thank you,

Mr. Dockery.

THE COURT: Cross examination, counsel.

MR. NOLAN: Just a quick cross, your Honor.

THE COURT: Yes, sir.

CROSS-EXAMINATION

BY MR. NOLAN:

Q. Good afternoon, Mr. Dockery.

A. Good afternoon, sir.

Q. You were talking about the MWAP period of the policy. Do you recall that?

A. Yes.

Q. You were talking about the various medications that you were trying during that time and your doctors were trying. Do you recall that?

A. Yes.

Q. I just want to make sure we go over what those were. You said you tried Depakote; is that correct?

A. Yes.

Q. You tried Elavil?

A. Yes.

Q. You tried Tegretol?

A. Yes.

Q. Did you try something called Copaxone?

A. Yes.

Q. Did you try Ditropan?

A. Yes.
Q. Tecfidera?
A. Yes.
Q. Cymbalta?
A. Yes.
Q. How about Topamax?
A. Yes.
Q. And those were all alternatives, if you will, as you understood it, to Neurontin or what the doctors were trying to use as alternatives?
A. Yes, most of them were.
Q. Did any doctor suggest that you weren't entitled to try an alternative?
A. I don't understand.
Q. In other words, they were prescribing you medications in order to treat your pain; correct?
A. Yes, they were.
Q. They weren't willfully trying to deprive you of any medication for your pain, were they?
MR. MORRISON: Objection.
THE COURT: Sustained.
Q. Are you claiming that those doctors were willfully trying to deprive you of any medication for your pain?
THE WITNESS: I can answer that?
Q. It's a yes or no question.

THE COURT: Yes, sir. Are you able to answer that?

A. Yes.

Q. You believe so, yes? Which doctor is that?

A. Well, it was a convoluted question because you said are they willingly?

Q. Is it your claim that any specific doctor was willfully trying to deprive you --

A. Oh, no, I do not feel that.

Q. They were trying to treat you with medications as an alternative to Neurontin; correct?

A. Yes.

Q. You've done marijuana in prison; correct?

A. Yes.

Q. On more than one occasion; correct?

A. No.

Q. You've been found guilty twice in prison of having used marijuana; correct?

A. No.

Q. You've been disciplined twice for it; correct?

A. Yes.

Q. You were part of an alcohol and substance abuse treatment program, too; correct?

A. Yes, I was.

Q. You're on Neurontin today?

A. Yes.

Q. You're going to be released in how long, three weeks?
A. About that.
Q. And do you plan to continue to use Neurontin then?
A. Yes.
Q. And you'll be outside of DOCCS' care at that point; correct?
A. Yes.
Q. Has anybody told you in the last six months that you couldn't take Neurontin because of MWAP?
A. In the last six months?
Q. Yeah.
A. I knew that before six months.
Q. Let me ask you this, as you sit here today, is MWAP, the policy, depriving you of Neurontin in any way?
A. Not any longer.
Q. Not any longer. Since it was rescinded and you haven't been deprived of Neurontin because of MWAP; correct?
A. Not because of MWAP.
Q. What is your claim, you've been deprived for other reasons is what your claim is?
A. I believe that there's also -- I think it's being missed, as well -- yes, it was a policy that was instituted and it wasn't going the right way for several reasons, but there's also a mindset that I think nobody's talking about, as well. Like, these doctors automatically say you're not going to get

that medication or you're not going to get that. So even though the policy is rescinded, that mindset, I still hear it, you know, like, oh, you're not going to get this medication because of this.

Q. But since it's been rescinded, you haven't been denied medication, Neurontin, because of any specific MWAP policy; correct?

A. No.

MR. MORRISON: Objection. Speculation.

A. Not that I know of.

Q. Do you recall being brought down to sick call in November of 2022 by security?

A. By security?

Q. Yes.

A. No. You got to refresh my memory.

Q. Do you recall being brought to the nurse while you were high?

A. No.

Q. Are you claiming that you were not high when you were brought to the nurse?

MR. MORRISON: Objection.

A. I --

THE COURT: Excuse me. When they say "objection," would you just hold your answer and then I'll tell you if you have to answer or not.

THE WITNESS: Okay. That's fine.

THE COURT: Objection.

MR. MORRISON: It's an improper question.

MR. NOLAN: Withdrawn.

Q. You testified earlier that you've used marijuana in prison; correct?

A. Yes.

Q. And I asked you earlier if, in November of this year, security brought you to sick call to see medical personnel. Do you recall that?

A. Yes, I do now.

Q. And when you were brought down, were you or were you not high?

A. I was not high.

Q. Were you under the influence of a substance that was not prescribed to you?

A. No, I was not.

Q. Were you slurring your words?

A. No, I was not.

Q. Do you think your medical records would actually reflect that?

A. I'm not sure.

Q. You would agree that in prison, there are other prisoners who hoard medication; correct?

A. I would assume that.

Q. Do you recall testifying in your deposition that you know that to be the case?
A. I mean, I don't really see it that often, but I would assume that it happens.
Q. You know it happens; correct?
MR. MORRISON: Objection. Argumentative.
THE COURT: This is cross.
Are you able to answer that, sir?
THE WITNESS: Yes.
THE COURT: Go ahead.
A. Yes, I would assume that, yes. You hear about it, I don't see it, but you hear about it.
Q. And you hear about it being bought and sold; correct?
A. Yes.
Q. Are you claiming damages in this case?
MR. MORRISON: Objection. Irrelevant.
Q. Are you claiming damages in this case?
THE COURT: I don't know that we're at that issue, are we? This is a PI hearing, isn't it?
MR. NOLAN: He's going to be released in three weeks. There's the question of whether there is irreparable harm or if there is alternative remedy.
THE COURT: I'm not sure we're there. Forgive me for not having memorized everything, but I think the only relief being sought is the PI at this point; isn't that right?

MR. NOLAN: Well, it looks that way from their latest set of disclosures that there's now actual damages claim and I just want to make sure --

THE COURT: Okay. So I think, probably, we need to move on.

MR. NOLAN: Okay.

Q. As you sit here today, what medications, other than Neurontin, are you on?

A. There's a whole list.

Q. Can you take me through it?

A. I'm on Tecfidera for my MS, I'm on baby aspirin from side effects from that. I'm also on Neurontin. I'm also on something called Keppra — this is an antiseizure medication, which is supposed to also help in conjunction with the Neurontin. I'm also on ibuprofen. I'm also on vitamin D3. I'm also on something for heartburn, I forget the name of it.

Q. In addition to the medications you're on, do you receive any equipment, do you receive any other type of treatment?

A. Yes. And also Baclofen. And yes, I do have a TENS unit.

Q. What's a TENS unit?

A. A TENS unit is an electrical device that's supposed to relieve you of pain.

Q. When is the last time that you saw your provider?

A. It's been a while.

Q. Were you recently offered the ability to go to a pain

specialist?
A. Yes.
Q. And did you deny that request?
A. Yes.
MR. NOLAN: I have no further questions.
THE COURT: Thank you. Redirect, counsel?
MR. MORRISON: Yeah, real quickly, your Honor.
REDIRECT EXAMINATION
BY MR. MORRISON:
Q. Mr. Dockery, you were just asked whether you recently requested or offered to go to pain management specialists and you denied that offer; correct?
A. Yes.
Q. Why did you do that?
A. Well, I can't remember specifically for that trip, but there's been three trips that I did deny. One I had parole, so I denied the trip and asked for it to be rescheduled. One trip I did not have a wheelchair to ambulate to and from the trip, so I asked for it to be rescheduled. Another trip, I actually had a legal visit from my counsel that's here. So, instead of having them come all the way here and not go on my legal visit, I refused that one.
Q. When you were offered to go to pain management, were you being prescribed Neurontin, Baclofen, and the other medications I think you said you kept for pain?

A. Yes.

Q. Was that adequate in treating you for the pain that you were in?

A. Yes.

MR. MORRISON: Nothing further.

THE COURT: Thank you. You may step down, sir.

(Witness excused)

All right, friends, what now? Do we have anything else we can do?

MS. AGNEW: We filled the spaces as much as we could for defendants, your Honor.

THE COURT: So nothing else; right?

MS. AGNEW: No.

THE COURT: So let's go ahead and break.

What time are we starting in the morning, friends? 10:00, 9:30? Is it Dr. Khan coming in?

MS. KILEY: Yes.

THE COURT: 10 o'clock. Thank you, counsel. Good afternoon. Thank you, Mr. Marshal, Ms. Marshal.

(Adjourned to February 7, 2023 at 10:00 a.m.)

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INDEX OF EXAMINATION

PLAINTIFF EXHIBITS

DEFENDANT EXHIBITS